This research consisted of two studies exploring the role of parents in seeking help for rural adolescents with depression. Study 1 revealed that parents of rural adolescents were able to identify the symptoms and severity of adolescent depression, as well as a need for help. The best predictor of parents' intentions to seek professional help was having themselves experienced a previous mental health problem. Study 2 revealed key barriers and facilitating factors that influenced the help-seeking process for parents of rural adolescents with depression. Overall, the findings offer support to the utility of parent-mediated pathways to care for adolescents with mental health problems, whilst highlighting the disadvantages faced by rural adolescents with depression in receiving appropriate mental health care.

Parent-Mediated Pathways to Care for Rural Adolescents with Depression

by

Rachel Jamieson
BBSc, PGDipPsych

A Research Report Submitted in Partial Fulfilment of the Requirements
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School of Behavioural and Social Sciences and Humanities
University of Ballarat
PO Box 663
University Drive, Mount Helen
Ballarat, Victoria 3353
Australia

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STATEMENT OF AUTHORSHIP

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Abstract

This research aimed to explore the role of parents in seeking help for rural adolescents with depression. In Study 1, the ability of rural parents to identify adolescent depression, and their intentions to seek help for such a problem, were examined via a self-report questionnaire. Three-hundred-and-four parents of adolescents recruited through secondary schools in rural Victoria, Australia, were included in this study. In Study 2, the help-seeking experiences of seven parents who had sought help for an adolescent with depression were explored via in-depth interviews. Results of Study 1 revealed that parents were able to identify the symptoms and severity of adolescent depression as well as identify a need for help. The best predictor of parents' intentions to seek help from professional help sources was the previous experience of a mental health problem by the parent. Findings from Study 2 revealed key barriers as well as facilitating factors that influenced the help-seeking process for parents of rural adolescents with depression. Barriers included difficulty differentiating between depression and adolescent development or physical illness, accessibility/availability of services, financial costs, burden felt by mothers as primary help-seekers, and perceived stigma of mental illness. Facilitating factors included parental self-efficacy and prior knowledge/exposure to depression, professionals involving/supporting parents, and informal support. Overall, the findings from both studies offer support to the utility of parent-mediated pathways to care for adolescents with mental health problems, whilst further highlighting the disadvantages faced by rural adolescents with depression in receiving appropriate mental health care.

Chapter 1: Introduction

Adolescent depression represents a significant mental health issue, making early and effective treatment critical. However, a large gap exists between those adolescents experiencing a mental health problem and those who access mental health services, and a large proportion of adolescents do not seek help on their own accord. In particular, adolescents with depression and adolescents living in rural communities face a particular disadvantage in the help-seeking process due to the nature both of the disorder and of the rural environment (Boyd et al., 2006). Parents have been identified as an important source of help to adolescents as they are in the position to play a key facilitatory role in the help-seeking process, thereby increasing the likelihood that adolescents will access professional care (Logan & King, 2001). This parent-mediated pathway may be particularly beneficial in the case of rural adolescents with depression who face additional barriers to help-seeking than adolescents residing in urban areas. However, research to date examining parent-mediated pathways to help-seeking has been scarce, and little is known about the unique experiences of rural adolescents with depression.

In the following section, an overview of the characteristics and features of adolescent depression will be presented. Consideration will be given to the various definitions and diagnostic criteria of depression, in the context of adolescent development, whilst also examining epidemiological data, typical course, outcomes, and treatment prognoses of adolescent depression.

Adolescent Depression

Adolescence represents a significant time of change in an individual's life (Hartos & Power, 1997; Feldman & Elliot, 1990). During this complex transition from childhood to adulthood, a dramatic number of biological, psychological, cognitive, and interpersonal changes occur over a relatively short period of time (Hartos & Power, 1997; Tram & Cole, 2006). Among these changes, adolescents reach physical and sexual maturity, develop increasing autonomy from parents, acquire skills to fulfil adult roles, and redefine social relationships with members of both the same and opposite sex, all of which impact upon their sense of self-identity as they emerge into adulthood (Feldman & Elliot, 1990; Tram & Cole, 2006). Given the critical changes occurring during adolescence, any disruption to this transition in the form of psychopathology could have a significant impact upon adolescents' successful attainment of these developmental goals and subsequent functioning in adulthood. As such, the investigation of high prevalence disorders, such as depression, in adolescence represents a highly significant area of research.

Clinical Characteristics of Adolescent Depression

The term *depression* has been used to describe varying levels of clinical and subclinical phenomena (Reynolds, 1994). Depression can be defined at the level of a symptom, a syndrome, or a clinical disorder, with each reflecting differing degrees of psychopathology (Kendall, Cantwell, & Kazdin, 1989; Petersen et al., 1993). At the individual symptom level, *depressed mood* refers to an emotional state characterised by feelings of sadness or unhappiness (Petersen et al., 1993). A *depressive syndrome* refers to a group of associated behaviours and emotions (symptoms) without, however, imposing the stringent diagnostic criteria necessary to make a formal diagnosis of disorder (Reynolds, 1994). In contrast, *clinical depression* assumes not

only the presence of a depressive syndrome, but also requires that these symptoms be associated with clinically significant levels of current distress, and impairment to the individual's everyday functioning (Compas, 1997; Petersen et al., 1993). The clinical definition of depression assumes a disease model of psychopathology, whereby a discrete categorical approach is employed to diagnose depression as a clinical disorder (Compas, 1997; Reynolds, 1994).

The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (*DSM-IV-TR*; American Psychiatric Association, 2000) provides a taxonomic system for the diagnosis of clinical depression. Two forms of unipolar depression are listed in the *DSM-IV-TR*: Major depressive disorder and dysthymic disorder. Major depressive disorder is characterised by the presence of one or more major depressive episodes. The diagnostic criteria for a major depressive episode are provided in Table 1. Features of a major depressive episode include depressed mood (or irritable mood in children and adolescents), lack of interest or pleasure (anhedonia), and a range of somatic, cognitive, and behavioural symptoms (Kronenberger & Meyer, 2001). Such symptoms are severe and occur within a short period of time (i.e., two weeks). In contrast, dysthymic disorder is characterised by pervasive and chronic depressive symptoms (Kronenberger & Meyer, 2001). These symptoms are typically less severe than those experienced in a major depressive episode and occur over a longer duration (i.e., at least one year in adolescents). The diagnostic criteria for dysthymic disorder are presented in Table 2.

Table 1

DSM-IV-TR Criteria for Major Depressive Episode

A.	Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.
(1)	Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). **Note:** In children and adolescents, can be irritable mood.
(2)	Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others)
(3)	Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% body weight in a month), or a decrease or increase in appetite nearly every day. **Note:** In children, consider failure to make expected weight gains.
(4)	Insomnia or hypersomnia nearly every day
(5)	Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)
(6)	Fatigue or loss of energy nearly every day
(7)	Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)
(8)	Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)
(9)	Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide
B.	The symptoms do not meet the criteria for a Mixed Episode
C.	The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
D.	The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).
E.	The symptoms are not better accounted for by Bereavement…

Table 2

DSM-IV-TR Criteria for Dysthymic Disorder

A. Depressed mood for most of the day, for more days than not, as indicated either by subjective account or observation by others, for at least 2 years. **Note:** In children and adolescents, mood can be irritable and duration must be at least 1 year.

B. Presence, while depressed, of two (or more) of the following:

   (1) poor appetite or overeating
   (2) insomnia or hypersomnia
   (3) low energy or fatigue
   (4) low self-esteem
   (5) poor concentration or difficulty making decisions
   (6) feelings of hopelessness

C. During the 2-year period (1 year for children or adolescents) of the disturbance, the person has never been without the symptoms in Criteria A and B for more than 2 months at a time.

D. No Major Depressive Episode has been present during the first 2 years of the disturbance (1 year for children and adolescents); i.e., the disturbance is not better accounted for by chronic Major Depressive Disorder, or Major Depressive Disorder, In Partial Remission.

E. There has never been a Manic Episode, a Mixed Episode, or a Hypomanic Episode, and criteria have never been met for Cyclothymic Disorder.

F. The disturbance does not occur exclusively during the course of a chronic Psychotic Disorder, such as Schizophrenia or Delusional Disorder.

G. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug or abuse, a medication) or a general medical condition (e.g., hypothyroidism).

H. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:
Early Onset: if onset is before age 21 years
Late Onset: if onset is age 21 years or older

The diagnostic criteria for major depressive disorder and dysthymic disorder are based on typical symptom expression in adults; however, some provisions have

been made for diagnoses in childhood and adolescence. Notably, the *DSM-IV-TR* recognises that irritability may be a prominent feature of child and adolescent depression, and that irritable mood may be substituted for depressed mood (Hammen & Rudolph, 2003). Whilst there has been some criticism of the use of adult criteria in the classification of childhood disorders, in that they may overlook important development considerations (Hazler & Mellin, 2004; Kendall et al., 1989), research suggests that the essential features of child and adolescent depression are consistent with those of adults (Parker & Roy, 2001).

For example, Carlson and Kashani (1988) compared the frequency of depressive symptoms in four clinically referred samples: preschool children (n = 9), prepubertal children (n = 95), adolescents (n = 92), and adults (n = 100). Findings demonstrated that whilst symptoms of anhedonia, diurnal variation, hopelessness, psychomotor retardation, and delusions increased with age; and symptoms of depressed appearance, low self-esteem, and somatic complaints decreased with age; symptoms of depressed mood, diminished concentration, insomnia, and suicidal ideation remained similar across the developmental span. From these findings, Carlson and Kashani concluded that whilst symptom frequencies may vary across the lifespan, the basic phenomenology of depression remains constant. Similar findings have also been reported elsewhere (e.g., Kashani, Rosenberg, & Reid, 1989; Patton, Coffey, Posterino, Carlin, & Wolfe, 2000; Ryan et al., 1987), supporting the use of adult-based diagnostic criteria to conceptualise depressive disorders in adolescents.

In considering the clinical presentation of adolescent depression, it is also important to take into account how unique developmental features of adolescence influence the diagnosis of depressive disorders. To many, including lay people and professionals alike, adolescence has been perceived as a period of emotional instability and turmoil (Offer & Schonert-Reichl, 1992; Petersen et al., 1993). Mood

swings, irritability, withdrawal, alterations in eating and sleeping patterns, decreased engagement in reinforcing activities, and difficulties concentrating have all been considered to be normative variations in adolescent behaviour, or part of a "phase" that the adolescent will eventually outgrow (Reynolds, 1994). This conceptualisation of adolescence as the "terrible teens" has, however, been challenged by evidence that the majority of adolescents traverse this developmental period without experiencing significant difficulties (Offer & Schonert-Reichl, 1992; Petersen et al., 1993). Whilst it would appear that adolescence is not the tumultuous time it was once thought to be, misguided perceptions of adolescents "just going through a moody stage" are still pervasive and have the potential to be quite damaging for adolescents who are experiencing a psychological problem. For those adolescents suffering from a depressive disorder, this may mean that their symptoms may be overlooked, go undetected, and be under-treated due to misconceptions about what constitutes normal adolescent development (Reynolds, 1994).

In summary, clinical depression differs from depression as a symptom or a syndrome due to its use of stringent diagnostic criteria, such as that listed in the DSM-IV-TR. Whilst these diagnostic criteria are largely based on adult symptom expression, some provisions have been made for the diagnosis of adolescent depression. Additionally, research has shown that the phenomenology of depression is similar between adults and adolescents. However, misconceptions of adolescence as a period of turmoil and emotional lability may lead symptoms of depression among adolescents to be minimised, ignored, or overlooked by lay people and professionals alike. In the following section, epidemiological data pertaining to the prevalence, gender ratios, and secular trends in adolescent depression will be reviewed.

Epidemiology of Adolescent Depression

Depressive disorders are among the most common forms of psychopathology affecting adolescents (Newman et al., 1996). The incidence of depression has been shown to rise sharply from childhood to adolescence (Kashani et al., 1989), with prevalence rates of depressive disorders ranging from 0.4% to 2.5% in children to 0.4% to 8.3% in adolescents (Birmaher et al., 1996; Kashani et al., 1989). Estimates of lifetime prevalence of depression among adolescents ranges from 15% to 20%, with these rates being comparable to the lifetime prevalence of depression for adults (Birmaher et al., 1996; Kessler & Walters, 1998; Reinherz, Giaconia, Lefkowitz, Pakiz, & Frost, 1993). Among Australian adolescents, depression rates ranging from 3% to 14.2% have been reported (Boyd, Kostanski, Gullone, Ollendick, & Shek, 2000; Patton et al., 1999; Sawyer et al., 2000; Sawyer, Miller-Lewis, & Clark, 2007). Recent figures released by the Australian Bureau of Statistics (2008) indicate that one in four Australians aged between 16 and 24 years have a mental disorder, with 6.3% of this age group experiencing an affective disorder (depressive episode, dysthymia, or bipolar affective disorder).

Rates of depression have also been found to differ substantially between male and female adolescents (Allgood-Merten, Lewinsohn, & Hops, 1990; Garber, 2006; Hazler & Mellin, 2004; Hofstra, van der Ende, & Verhulst, 2002; Nolen-Hoeksema & Girgus, 1994; Rushton, Forcier, & Schectman, 2002; Wade, Cairney, & Pevalin, 2002). In children, major depressive disorder occurs at a similar rate between boys and girls; however, distinct gender differences emerge in adolescence with girls manifesting higher rates than boys between the ages of 13 to 14 years (Hankin et al., 1998; Nolen-Hoeksema & Girgus, 1994; Wade et al., 2002). The female to male ratio of adolescent depression is approximately 2:1, which corresponds with the gender ratio found in adults (Angold, Erkanli, Silberg, Eaves, & Costello, 2002; Garrison,

Jackson, Marsteller, McKeown, & Addy, 1990; Harrington, Fudge, Rutter, Pickles, & Hill, 1990; Kessler & Walters, 1998). Whilst the reason for this change in gender distribution remains unclear, links with biological changes associated with puberty, genetics, sociocultural factors, and increased prevalence of anxiety disorders among females have all been postulated (Birmaher et al., 1996; Ge, Conger, & Elder, 2001; Nolen-Hoeksema & Girgus, 1994; Parker & Roy, 2001; Steiner, Dunn, & Born, 2003).

A further disturbing trend in the epidemiology of adolescent depression is the secular increase in depression rates seen in recent cohorts (Birmaher et al., 1996; Gotlib & Hammen, 1992; Kessler & Walters, 1998; Kovacs & Gatsonis, 1994). Research suggests that individuals born in the later part of the 20th century have a higher risk of developing a depressive disorder, and that first-onset of depression is manifesting at an earlier age (Birmaher et al., 1996; Kovacs & Gatsonis, 1994; Parker & Roy, 2001). For example, a national survey of 1,769 adolescents and young adults reported a secular increase in lifetime prevalence rates of depressive disorders across successive cohorts (Kessler & Walters, 1998). Whilst these findings were based on retrospective reports, the authors found that cohort effects still existed after controlling for age-associated increases in failure to recall depressive episodes. The reasons for such increases remain speculative, but have largely been attributed to environmental factors, given that the genetic make-up of the population has not altered substantially during the time that depression rates have increased (Birmaher et al., 1996; Gotlib & Hammen, 1992).

To summarise, depression represents a serious mental health problem for adolescents, with lifetime prevalence rates being comparable to those found in adulthood. During adolescence a distinct gender difference emerges, with female adolescents being twice as likely as males to suffer from depression. Of particular

concern is research showing an increasing rate of depression among recent birth cohorts, and evidence that first-onset of depression is occurring at an earlier age than in the past. Next, consideration will be given to the projected course, outcomes, and prognoses of adolescent depression.

Course and Outcomes of Adolescent Depression

Depression is widely viewed to be a disorder of adolescent beginnings, with mid- to late-adolescence having been identified as a common age of onset (Costello, Egger, & Angold, 2005; Hammen & Rudolph, 2003; Lewinsohn, Clarke, Seeley, & Rohde, 1994). The emergence of depression in adolescence tends to be insidious rather than acute, and may often go unrecognised, be mistaken for other problem behaviours, or considered to be a normative variation in adolescent development (Parker & Roy, 2001; Reynolds, 1990, 1994). Episodes of major depression among adolesents have been reported to last between 7 to 9 months on average, with 90% remitting within 1 to 2 years (Birmaher et al., 1996). Adolescent depression has, however, been associated with high rates of relapse, with a 40% cumulative probability of reccurence by 2 years, and 70% reccurence rate by 5 years (Birmaher et al., 1996). Furthermore, having a depressive disorder may interfere with an adolescent's ability to function competently across social, emotional, cognitive, interpersonal, and academic domains (Compas, 1997; Gotlib & Hammen, 1992; Reynolds, 1994), and has also been demonstrated to share strong links with other dangerous or high risk behaviours such as suicide and suicide attempts, sexual promiscuity, smoking, and drug and alcohol abuse (Kovacs, Goldston, & Gatsonis, 1993; Reynolds, 1994; Rodriguez, Moss, & Audrain-McGovern, 2005; Sawyer et al., 2007).

Considering long term prognoses, earlier age of onset of depression predicts a more severe and protracted course, and is associated with a higher risk of depression and other mental illnesses in adulthood (Birmaher et al., 1996; Dekker et al., 2007; Gotlib & Hammen, 1992; Harrington, Rutter, & Fombonne, 1996; Kovacs, Feinberg, Crouse-Novak, Paulauskas, & Finkelstein, 1984; Petersen et al., 1993; Rao et al., 1995; Sourander & Helstelä, 2005). In a longitudinal follow-up of child and adolescent depression, 149 particpants who had attended a child psychiatric department of a London hospital 20 years previous with a diagnosis of major depressive disorder were interviewed regarding lifetime rates of psychiatric disorder (Fombonne, Wostear, Cooper, Harrington, & Rutter, 2001). Eighty-six percent of the sample reported at least one episode of mental illness over the 20 year period, with 62.5% reporting at least one recurrent episode of major depression, and 75.2% reporting some form of depressive disorder as adults. These high recurrence rates support the view that onset of depression in adolescence carries an elevated risk for subsequent depressive episodes in adulthood (Fombonne et al., 2001; Ge et al., 2001; Harrington et al., 1990; Rao et al., 1995; Tram & Cole, 2006).

Not only does adolescent onset of depression increase the risk of future mental health problems, but having a depressive disorder in adolescence can also lead to significant functional impairments. During adolescence, depression can cause disruptions in attaining developmental goals and acquiring skills in preparation for adulthood (Gotlib & Hammen, 1992). Furthermore, even if depressive symptoms remit, there are likely to be lasting impairments in academic, interpersonal, and cognitive functioning that extend into adulthood (Gotlib & Hammen, 1992; Parker & Roy, 2001). For example, upon long-term follow-up of 73 depressed adolescents, Weissman et al. (1999) reported that in addition to an increased risk for subsequent depressive episodes, these adolescents also experienced higher rates of suicide and

suicide attempts, and impairments in work, social, and family life than did control subjects. Similarly, Fergusson and Woodward (2002), examining longitudinal data of 1,265 children with depression, found that these individuals were at increased risk of adverse psychosocial outcomes in late adolescence and early adulthood, including nicotine dependence, alcohol abuse or dependence, suicide attempts, educational underachievement, unemployment, and early parenthood. Thus, not only does adolescent depression hold an increased risk for subsequent depressive episodes, but having depression as an adolescent does not appear to bode well for future functioning across a variety of domains (Berndt et al., 2000; Fergusson & Woodward, 2002; Weissman et al., 1999).

In summary, depression often first develops in adolescence, with earlier age of onset predicting a more severe and protracted course. Adolescent depression is associated with high rates of relapse and subsequent mental health problems in adulthood, and has been shown to have strong links with other life threatening behaviours such as suicide and drug and alcohol abuse. Furthermore, having depression during adolescence may also compromise functioning in other life areas, such as academic, cognitive, and interpersonal domains, with the consequences of this impairment during adolescence extending into adulthood.

Overall, depression represents a serious mental health issue for the adolescent population. The negative outcomes and poor prognoses associated with adolescent depression suggest that early interventions aiming to minimise the symptoms and subsequent adverse effects of this disorder are imperative. In fact, research indicates that delays between the onset of mental health problems and obtaining effective treatment contribute to poorer outcomes (Steinhausen, Rauss-Mason, & Serdel, 1991; Stephenson, 2000), whilst seeking professional help for a psychological problem has been shown to reduce the risk of subsequent disorder (Feehan, McGee, & Stanton,

1993; Parker & Roy, 2001). Therefore, in order to reduce the negative outcomes associated with adolescent depression, it is critical for adolescents with depressive disorders to obtain appropriate and effective treatment as soon as possible (Birmaher et al., 1996). Consequently, the following section will focus on mental health service utilisation by adolescents.

Mental Health Service Use

In this section, rates of mental health service utilisation by adolescents, including those with depression, will be considered, and factors associated with access to mental health services among adolescents will be reviewed. Additionally, the circumstances of a unique segment of the adolescent population who have been identified as facing additional barrieirs in accessing mental health services – those living in rural, regional, and remote areas – will be examined.

Mental Health Service Use by Adolescents

A growing body of evidence suggests that only a small proportion of children and adolescents with psychological disorders receive professional help (Sawyer et al., 2000). This is particularly the case when it comes to the provision of specialised mental health services, with a large gap between the prevalence of mental health problems and rates of service utilisation having been identified (Costello, Pescosolido, Angold, & Burns, 1998). The majority of research suggests that less than 50% of children and adolescents with psychological disorders access professional care, with reported rates ranging from 13% to 54% (Cohen, Kasen, Brook, & Struening, 1991; Cuffe et al., 2001; Goodman et al., 1997; Sawyer et al., 2000, 2007; Verhulst & Van der Ende, 1997; Zahner, Pawelkiewicz, DeFrancesco, & Adnopoz, 1992).

The child and adolescent component of the National Survey of Mental Health and Well-being (Sawyer et al., 2000) provided the first large scale account of service utilisation by Australian adolescents, surveying a representative sample of 4,509 children and adolescents aged from 4 to 17 years. Mental disorders were assessed using the parent-version of the Diagnostic Interview Schedule for Children Version IV (DISC-IV), whilst parents also completed the Child Behaviour Checklist (CBCL) and a standard questionnaire to assess service use. Key findings with regards to service use indicated that in the 6 months prior to the survey, 25% of children and adolescents scoring in the clinical range on the CBCL had attended one or more services, and only 29% of those with a diagnosable mental disorder had attended at least one service. Of the children and adolescents whose parents reported that their child needed professional help, only 45% had accessed care in the previous six months. For children meeting all three of the above criteria (scoring in the clinical range on CBCL, having a mental disorder, and parents reporting they needed professional help), only half had attended a service for help with their problems. Due to data for children and adolescents being reported here together, the applicability of these findings specific to adolescents is somewhat limited.

Addressing this, Sawyer et al. (2007) later examined patterns of service use specific to the 1490 adolescents (aged 13 to 17 years) who took part in the study. Mental health problems were assessed through both parent and adolescent reports via the CBCL and the Youth Self Report (YSR), respectively. Findings showed that in the 6 months prior to the survey, 31% of adolescents scoring in the clinical range on the CBCL had attended one or more services, and only 20% of those scoring in the clinical range on the YSR had attended at least one service. Amongst those adolescents who scored in the clinical range on both the CBCL and YSR, 33% had accessed care in the previous six months. Whilst only sampling from a cross-section

of the population, the large scope of this survey provides a strong indication that only a minority of Australian adolescents with mental health problems receive professional help. Furthermore, adolescents identified as having a mental health problem based on parent reports were more likely to attend services, highlighting adolescents' need for assistance from parents to access professional help.

In another large epidemiological study, Verhulst and Van der Ende (1997) investigated mental health service utilisation in a Dutch sample of 2,227 children and adolescents aged 4 to 18 years. The CBCL and the Youth Adult Self-Report were used to identify problem behaviours, whilst demographic and service utilisation data were obtained through interview. Results showed that 13% of children who had a CBCL Total Problem score in the deviant range (n = 428) were referred for mental health services, and 14% of children whose parents reported that their child had a behavioural/emotional problem (n = 440) were referred. Of the 139 children whose parents indicated that their child's problems were worse than those of other children, 30% were referred, suggesting that the likelihood of receiving mental health services where higher when parents perceived their child to have a significant problem. The service utilisation rates reported in this study were all slightly lower than those reported by Sawyer et al. (2007), possibly varying as a function of the different populations under study. However, they do provide additional evidence to suggest that only a small proportion of children with psychological problems receive mental heath services, though longitudinal research is necessary to identify patterns of service use over time.

In one of the few longitudinal studies examining mental health service use, Cuffe et al. (2001) assessed a stratified sample of adolescents at three intervals: Cycle One (n = 579, mean age = 12.83 years), Cycle Two (n = 420, mean age = 18.65 years), and Cycle Three (n = 330, mean age = 20.60 years). Participants were first

screened using the Center for Epidemiologic Studies Depression Scale (CES-D), and from this, selected for diagnostic evaluation using the Schedule for Affective Disorders and Schizophrenia for School Aged Children and the Children's Global Assessment Scale. Service use was assessed through a mailed questionnaire at Cycle Three. Cuffe et al. found that in early adolescence, 54% of participants diagnosed with a psychiatric disorder had received some sort of professional help. At Cycle Two, only 33% of adolescents diagnosed with a psychiatric disorder had received mental health treatment in the past year, whilst this decreased to 20% at Cycle Three. Overall, service use decreased over time, with fewer participants accessing treatment as they progressed through adolescence. However, reasons for this decrease in service use were not assessed.

Research on service utilisation by children and adolescents with psychological disorders as a whole is growing. However, the relationship between mental health service use and specific disorders such as depression have received less attention. To address this gap in the literature, Wu et al. (2001) examined patterns of mental health service use in a sample of 206 children and adolescents (aged 9 to 17 years), who met the *DSM-III-R* criteria for either major depression or dysthymic disorder. Self-report data from parents and children indicated that 64% had received professional help for depressive symptoms. Children who accessed professional help were more likely to report a greater number of depressive symptoms and higher levels of impairment than those that did not, with their parents also being more likely to report that their child needed mental health services. Whilst service use by this sample was greater than that reported in other studies of *overall* psychopathology, findings nevertheless indicated that depression is under treated in children and adolescents.

In comparison to other mental disorders, children and adolescents with depression appear even less likely to receive treatment due to the internalising nature

of depressive symptoms (Cohen et al., 1991). In an earlier study, Wu et al. (1999) investigated the differing patterns of mental health service use of children with depression and children with disruptive disorders. A community sample of 1,285 children and adolescents aged 9 to 17 years participated in this study. Child psychopathology was assessed using the DISC, and data on mental health service use were obtained through child and parent interviews. Results demonstrated that children with disruptive disorders were more likely to have accessed mental health services (56%) than children with depression (38.6%), with parents of children with disruptive disorders also being more likely perceive child service need (51.5%) than those with a depressive disorder (36.4%). In contrast, children with depressive disorders were more likely to perceive a need for services (35%) than those with disruptive disorders (22.9%). These findings suggest that children with internalising problems are under-identified, and clearly highlight the unmet service need of children and adolescents with depression.

In summary, a sizeable gap exists between those children and adolescents with psychological disorders and those who receive treatment from mental health services. Only a minority of adolescents with mental health problems receive professional help, and it is possible that adolescents with depression access care less frequently as they get older. In the next section, the unique circumstances of people living in rural and remote locations with regards to mental health service use will be considered.

Rural Mental Health Service Use

Traditional conceptualisations of rural life conjure up images of an idyllic, harmonious, and supportive community, as opposed to the chaos, alienation, and stress of the city (Blank, Fox, Hargrove, & Turner, 1995; Centre for Adolescent Health & Youth Affairs Council of Victoria, 2002). However, for many people living

in country areas the reality of rural life is far from this idealised view (Blank et al., 1995; Cloke, 1996; Cloke, Milbourne, & Thomas, 1997). In this section, a number of factors related to the mental health of rural residents and barriers they incur in accessing mental health services will be considered. Following this, research specifically focussing on mental health service use by rural adolescents will be considered.

It is known that rural residency impacts upon health status, with rural communities facing distinct health disadvantages (Trickett, Titulaer, & Bhatia, 1997). People living in remote and rural communities experience poor physical health, demonstrating higher levels of mortality, disease incidence, rates of hospitalisation, and health risk factors than their urban counterparts (Strong, Trickett, Titulaer, & Bhatia, 1998; Trickett et al., 1997). It is therefore hardly surprising that rural communities have also been identified as an "at risk" population for mental health problems (Fraser et al., 2002; Judd, Murray, et al., 2002).

A number of factors specific to the rural lifestyle have been identified that are likely to influence the mental health status of residents. Rural communities tend to be poorer, older, less educated, have lower life expectancies, are more likely to be uninsured, and experience higher rates of interpersonal violence and suicide than metropolitan areas (Fraser et al., 2002; Human & Wasem, 1991; Jameson & Blank, 2007; Judd, Jackson, et al., 2002; Judd, Fraser, et al., 2002). The physical nature of the environment in which rural residents live means they are more isolated as well as more susceptible to environmental hazards such as floods, fires, and droughts (Fuller, Edwards, Procter, & Moss, 2000). The structure of rural life has also seen substantial changes in recent years, with traditional farming becoming less viable due to the impact of factors such as globalisation and economic restructuring (Judd, Fraser, et al., 2002; Judd, Jackson, et al., 2002). Thus, rural residents are exposed to a number

of stressors that place them at risk of developing mental health problems (Letvak, 2002).

To understand the difficulties faced by rural people in accessing mental health services, a situated approach that considers the relationship between rural "place", mental health, and care is needed (Boyd, Hayes, Sewell, et al., 2008; Jackson et al., 2007; Judd & Humphreys, 2001; Parr & Philo, 2003). Place, in this context, reflects a broad term that encompasses the geographical, social, cultural, economical, and political aspects of the rural environment (Fraser et al., 2002; Parr & Philo, 2003; Thompson Fullilove, 1996), all of which impact upon an individual's ability to access mental health care.

The social-geographical relationships of rural communities are quite distinct from those found in urban centres. Whereas urban dwellers are characterised as being *physically proximate* but *socially distant*, the opposite is thought to be true of rural areas (Boyd & Parr, 2008; Parr & Philo, 2003; Parr, Philo, & Burns, 2004). Rural relationships are typified by *physical distance* between neighbours but closer *social proximity* than is typical in urban relationships. That is, despite living some distance apart, rural residents may know intimate details about each other's personal histories and be well-informed about the everyday activities of people in their community (Parr & Philo, 2003; Parr et al., 2004). Whilst this level of social proximity may lead to the assumption that rural communities are more caring and supportive of their members, this may not necessarily be the case, particularly for those experiencing mental illness (Parr & Philo, 2003).

Cultural beliefs and attitudes regarding mental illness, and about seeking help for such problems, are thought to act as barriers to accessing mental health services for rural people (Boyd et al., 2007; Fuller et al., 2000). Attitudes towards mental illness in rural communities tend to be negative, holding traditional values against that

which is deviant or "out-of-the-ordinary" (Letvak, 2002; Parr et al., 2004). Thus, rural people may avoid mental health care when needed due to the stigmatising attitudes attached to mental illness in their community (Cooper, Corrigan, & Watson, 2003; Hoyt, Conger, Gaffney Valde, & Weihs, 1997). Additionally, rural communities have been characterised by a culture of self-reliance and stoicism (Boyd et al., 2007; Francis, Boyd, Aisbett, Newnham, & Newnham, 2006; Parr & Philo, 2003). Rural people are used to "getting by" on their own, and "soldiering on" in times of adversity; thus, seeking help would be contrary to their norms of non-disclosure and self-reliance (Parr & Philo, 2003; Parr et al., 2004). Therefore, despite the social proximity of rural communities, stigmatising attitudes towards mental illness and norms against seeking help for emotional problems may create a lack of support for community members. These factors, coupled with the visibility of people's personal lives to the community, are likely to prevent rural residents from seeking mental health services.

Examining the social geographies of mental health in a rural setting, Parr et al. (2004) interviewed 100 users of psychiatric services in the rural and remote Scottish Highlands. Regarding inclusionary and exclusionary (e.g., social stigma) experiences of the mental health service users, both acceptance and tolerance as well as rejection and intolerance were reported. Other major themes included a culture of silence regarding mental health problems, with traditional values of stoicism, emotional resilience, and self-containment being strongly felt by rural residents. Also, the visibility and lack of privacy of rural life, further perpetuated via community gossip, was reported to occupy a pivotal role in the lives of rural people with mental illness. Whilst the place of rural people with mental health problems is not clearly defined, sociocultural aspects of rural communities are likely to have a considerable effect on

the acceptance of people with mental health problems and on their decision to use mental health services.

In addition to sociocultural factors of rural life influencing mental health service use, systems of mental health service delivery in rural and remote communities also limit the availability, accessibility, and acceptability of psychiatric care (Blank et al., 1995; Human & Wasem, 1991; Stefl & Prosperi, 1985). *Availability* refers to the existence of mental health services and specialised personnel to staff services (Human & Wasem, 1991). This is one of the major problems faced by rural communities, with relatively few services existing outside metropolitan areas and a severe shortage of mental health professionals willing to work in rural areas (Jameson & Blank, 2007; Judd & Humprheys, 2001; Judd, Fraser, et al., 2002). The *accessibility* of mental health services is another pertinent issue for rural residents, who may have to travel long distances to receive treatment (Aisbett, Boyd, Francis, Newnham, & Newnham, 2007; Fraser et al., 2002; Jameson & Blank, 2007). This may be inconvenient or even impossible for those who have limited means of transportation or are limited by time constraints (Human & Wasem, 1991). Finally, *acceptability* refers to whether services are delivered in a way that is congruent with local values and appropriate to the rural setting (Human & Wasem, 1991; Judd, Murray, et al., 2002). As previously discussed, traditional beliefs about dealing with one's own problems, stigmatising attitudes towards mental illness, and concerns about confidentiality can lead to avoidance of mental health services by rural people with mental illnesses (Parr & Philo, 2003). However, this avoidance may be further intensified if mental health professionals, who are often trained in metropolitan areas, do not adopt an orientation appropriate to the rural culture or the traditional value systems of their clients (Human & Wasem, 1991).

In a qualitative study aiming to understand the influence of rurality on people's responses to mental health problems, Fuller et al. (2000) interviewed 22 key informants in South Australia. Informants included mental health professionals, other human service workers, general health professionals and mental health consumers. Three major themes emerged: reluctance to acknowledge mental health problems and the avoidance of appropriate help, stigma and the avoidance of mental health services, and the influence of rural and remote environmental circumstances. In relation to the first theme, informants described community views as equating mental illness with insanity, thereby making them reluctant to identify distress as a mental health issue and decreasing their likelihood of seeking help. With regards to the second theme, all people interviewed described a high degree of stigma associated with mental health problems in a rural context and many also described an associated feeling of fear. Thus, even for those recognising their distress, the fear of stigma associated with mental health problems may prevent rural residents from accessing care. Finally, circumstances unique to rural and remote communities such as economic conditions (e.g., economic downturn, loss of industry, unemployment) were reported as barriers to seeking professional help.

Research on the mental health of people living in rural areas suggests they are a high-risk group for mental health problems, who face a number of barriers to mental health service use. However, much of this research to date has focussed on issues of rurality as they apply to adults, and it is unclear as to how such factors would impact upon the experiences of mental health service use of rural adolescents. In the next section, emerging research in the area of rural adolescent mental health service use will be considered in order to gain insight into how aspects of rural place affect adolescents with mental health problems in seeking care.

Mental Health Service Use by Rural Adolescents

Whilst clear challenges exists for both people living in rural communities and also for the general adolescent population in accessing mental health services, little consideration has been given as to how these factors combined may impact upon mental health service use. Recent research is, however, beginning to emerge addressing the specific experiences of rural adolescents in utilising mental health services. In this section, studies addressing mental health service use by rural adolescents will be considered, with a particular focus on the challenges unique to rural place as a context for mental health care.

Cohen and Hesselbart (1993) examined demographic factors (including rurality) related to mental health service use by 760 American youths aged 12 to 20 years. Information was gathered via interviews of mothers and of adolescents. In relation to mental health service use, the study found that adolescents living in rural areas were significantly less likely to receive mental health services than those in larger communities, with only 5% of rural youth accessing any form of mental health service. This pattern of service use was consistent with that of adults, suggesting that adolescents in rural communities also experience an unmet need for mental health services. However, the focus of this study was not on rural adolescents per se, indicating a need for further research directed specifically towards the issues surrounding mental health service utilisation in this population.

Addressing this issue, Francis et al. (2006) explored the attitudes of rural adolescents towards seeking help for mental health problems via focus groups conducted with 52 students from rural secondary schools in Victoria, Australia. In these focus groups, students were presented with hypothetical scenarios depicting an adolescent living in a rural area with a mental disorder and corresponding questions that were used to generate group discussion. Through the use of qualitative analysis,

results revealed several barriers to help-seeking that could be considered unique to rural settings. Barriers identified included a perceived lack of local specialist services and a consequent need to travel in order to access services, fear of stigma and social exclusion, lack of anonymity perpetuated through rural gossip networks, and a view that mental health problems were a sign of weakness. Adolescents expressed positive attitudes toward seeking help from professional sources (with the exception of general practitioners), particularly those that were school-based. A preference for informal sources of support, such as parents and friends, was reported with emphasis placed on the mediating role that parents play in assisting adolescents to obtain help.

In another qualitative study, Boyd et al. (2007) interviewed six first year university students (aged 17 to 21 years) who had sought help for a mental health problem as an adolescent whilst residing in a rural town. Consistent with the findings of Francis et al. (2006), participants identified a lack of anonymity, a culture of self-reliance which viewed mental illness as a sign of weakness, a fear of stigma associated with seeking help for a mental health problem, and a lack of knowledge about services available in their town as barriers to seeking psychological help in rural communities. Also similar to findings of the previous study, participants held the view that general practitioners (GPs) were not an appropriate source of help for a mental health problem and favoured school-based helpers. Participants reported a shared experience of having been offered assistance following a helper identifying the adolescents' distress and approaching the adolescent to offer help. The characteristics of helpers that were favoured by participants included available, caring, non-judgemental, genuine, and young professionals who were bound by confidentiality.

Finally, Aisbett et al. (2007) conducted a series of interviews with adolescents who were clients of public child and adolescent mental health services located in two rural cities of Victoria, Australia. Common themes described by participants included

a lack of reliable transport to and from services, concerns regarding lack of qualified professionals in their region specialising in child and adolescent mental health, and frustration with long waiting lists and lack of after hours services. Adolescents also described how the impact of rural gossip networks and social visibility compounded their experiences of stigma and social exclusion to a point that it negatively impacted on their on-going use of the service.

In summary, remote and rural populations share a number of common characteristics that place them at an increased risk for mental health problems. In addition to this, they appear to face a marked disadvantage in accessing mental health services due to geographical, social, cultural, economical, and political characteristics of rural places. Studies to date examining the experiences of rural adolescents in utilising mental health services have identified common challenges for this population. Barriers including fear of stigma and social exclusion, lack of anonymity and rural gossip networks, community attitudes that mental health problems are a sign of weakness, lack of and difficulties in accessing services (e.g., travel, long waiting lists), and a preference for school-based and informal supports were consistently identified in these studies. However, research to date has predominately been qualitative and exploratory in nature, limiting the ability to generalise these findings to all rural adolescents. Further research is needed to continue to develop our understanding of the unique challenges rural adolescents face in utilising mental health services.

Overall, research into mental health service use indicates that there is a high level of unmet need in the adolescent population (Sawyer et al., 2000, 2007). Whilst studies of mental health service use patterns by adolescents as a whole is growing, the relationship between mental health service use and specific types of psychopathology, such as depression, have received less attention. In addition to this, preliminary

research regarding mental health service use by rural adolescents indicates that they face many unique challenges that are yet to be sufficiently addressed. In order to improve our understanding of the low levels of mental health service utilisation in these populations, greater attention needs to be focussed on the processes leading to mental health use. That is, broadening the scope to focus on "help-seeking" rather than simply "help-getting" will provide the opportunity to identify factors that may inhibit or facilitate an individual's progress towards accessing mental health services (Cauce et al., 2002; Zwaanswijk, Verhaak, Bensing, van der Ende, & Verhulst, 2003). In order to gain a more comprehensive understanding of the pathways leading to mental health service use, the following section will review literature on help-seeking, with a particular focus on how this process unfolds for adolescents.

Help-Seeking: The Process Behind Mental Health Service Use

The purpose of this section will be to examine the processes leading to mental health service utilisation known as help-seeking. To begin, a stage based model will be presented as a theoretical framework for conceptualising the help-seeking process. Following from this, research examining help-seeking patterns of adolescents experiencing a psychological problem will be reviewed before turning to a specific focus on help-seeking by adolescents with depression.

Help-Seeking

Help-seeking has been defined as "an important subset of adaptive coping behaviours that involves asking for assistance and advice from available help sources" (Fallon & Bowles, 2001, p. 12). By seeking help, people aim to reduce or relieve distressing symptoms or escape an uncomfortable or troubling situation (Fischer, Winer, & Abramowitz, 1983). In relation to mental health service use, help-seeking

reflects the active process in which an individual engages to access mental health care and thereby obtain relief from their symptoms (Cauce et al., 2002; Fischer et al., 1983; Rickwood, Deane, Wilson, & Ciarrochi, 2005).

To understand the processes involved in seeking professional help, a number of stage models of help-seeking have been proposed. Whilst such models provide a useful framework through which to conceptualise the help-seeking process, they may also present an overly simplistic representation of help-seeking by implying that people's help-seeking journeys follow a logical, orderly, linear sequence (Fischer et al., 1983; Greenlay & Mullen, 1990; Murray, 2005). The process in which individuals engage to seek help is likely to be much more complex and influenced by a variety of factors, with individuals shifting between stages in unsystematic ways (Greenlay & Mullen, 1990; Murray, 2005). Whilst the limitations of stage models should be borne in mind, they nevertheless provide a useful structure for presenting help-seeking research (Greenlay & Mullen, 1990).

Whilst numerous stage models of help-seeking exist, three core stages involved in seeking help for a psychological problem are typically depicted within the various conceptualisations (Broadhurst, 2003; Kessler, Brown, & Broman, 1981). The three central stages of help-seeking are: (1) problem recognition, (2) deciding to seek help, and (3) actively seeking help. To gain a fuller understanding of how individuals experiencing a mental health problem traverse along this help-seeking path, each of the proposed help-seeking stages will now be considered in detail.

Before an individual seeks professional help, they must first come to recognise that they are experiencing unpleasant symptoms and identify that these symptoms are psychological in nature (Cauce et al., 2002; Fischer et al., 1983; Greenlay & Mullen, 1990; Kessler et al., 1981; Rickwood et al., 2005). Whether these symptoms are recognised as being problematic may depend on the severity of symptoms, number of

symptoms, impairment or disruption to everyday life caused by the symptoms, how obvious the symptoms appear to others, and the amount of anxiety or distress caused by the symptoms (Greenlay & Mullen, 1990). Once identified as problematic, the individual then searches for an explanation or understanding of their symptoms (Greenlay & Mullen, 1990). The types of attributions made regarding the cause of the symptoms (e.g., physical illness, interpersonal difficulties, stress, psychological difficulties) will determine how a person comes to define his or her problem and guide decisions about whether or not to seek help.

At the next stage, the individual contemplates ways of resolving or reducing their mental health problem (Fischer et al., 1983) . For some, this may involve waiting to see if the problem will rectify itself alone, taking self-corrective actions, asking others for informal assistance, or seeking professional help (Fischer et al., 1983). People may experiment with any mixture of these options with varying degrees of success before they develop the intention to seek professional help. At this point, the perceived benefits of seeking help are judged to outweigh the costs of taking such actions, and the individual decides to actively pursue help to deal with their problem (Cauce et al., 2002; Fischer et al., 1983).

Finally, having reached the decision that professional help is required to cope with their psychological difficulties, the individual then has to make a choice regarding the particular type of professional to see (Broadhurst, 2003; Greenlay & Mullen, 1990). Various sources of formal help exist (e.g., GPs, mental health professionals, counsellors, clergy), and the type of help an individual selects will be influenced by a variety of factors (Broadhurst, 2003; Fischer et al., 1983). Features of the professional or their agency (e.g., cost, quality of help, accessibility), social and cultural factors (e.g., embarrassment and stigma associated with seeking help for mental illness), and personal variables (e.g., self-esteem, self-worth) may all influence

this final stage of the help-seeking process (Fischer et al., 1983). Furthermore, such factors may act as barriers to help-seeking, thereby preventing access to services even when an individual is motivated to seek help.

In conclusion, help-seeking reflects the active process behind mental health service use through which the individual endeavours to obtain relief from their distressing symptoms. Help-seeking is characterised by three main stages: the individual must first come to recognise they have a problem, and then decide that they require help, before professional care is sought. The ways in which an individual comes to negotiate these stages is influenced by a number of factors, all of which have the potential to facilitate or impede their pathway to care. Therefore, to gain a better understanding of the large discrepancy between those individuals with a psychological problem and those who access professional care, greater attention should be focussed on the pathways leading to mental health service use. Specifically, a focus on the factors that impact upon these earlier stages of the help-seeking process will enable greater insight into the reasons for the majority of adolescents with mental health problems like depression not receiving professional help. In the following section, studies examining help-seeking in adolescence will be reviewed.

Adolescent Help-Seeking

Much consensus in the literature exists to indicate that a large proportion of adolescents do not seek help for psychological problems (Cuffe et al., 2001; Dubow, Lovko, & Kausch, 1990; Rickwood & Braithwaite, 1994; Saunders, Resnick, Hoberman, & Blum, 1994; Sawyer et al., 2000). However, less consideration has been given to the pathways leading to professional help or the factors which may impinge upon this process. In this section a number of studies examining help-seeking by adolescents will be reviewed. In the first part, general studies of help-seeking in

adolescence will be considered, followed by research examining the sources of help that adolescents seek. Finally, help-seeking experiences specific to adolescents with depression will be considered.

Examining help-seeking in response to an emotional problem, Rickwood and Braithwaite (1994) examined a sample of 404 Australian adolescents aged 16 to 19 years (M = 17.4 years). Current mental health status was assessed using the General Health Questionnaire, and two questions regarding help-seeking were administered. Results showed that 27% of adolescents in this sample were moderately to severely distressed. Of these adolescents, 23% had not sought any help for their problems and only 17% had sought professional help. Eighty-six percent of adolescents who sought help did so through family and friends, indicating that informal sources of help were preferred over formal ones. Also, a pronounced gender effect was found, with girls being more likely to seek help than boys. This study, however, did not directly address whether participants perceived themselves as having a problem or whether they felt they needed help. As such, these early stages of the help-seeking process can only be inferred from help-seeking outcomes in this study.

In a study addressing all steps in the help-seeking process, Saunders et al. (1994) examined formal help-seeking behaviour of 17,193 American adolescents from Grades 7 through to 12. All students completed the Adolescent Health Survey. However, the rural area survey did not contain the key question relating to the dependent variable (help-seeking) and as such, only responses from students in metropolitan areas were examined. Twenty-five percent of the overall sample identified themselves as having a mental health problem. Of these respondents, 50.4% indicated a need for professional help, of which only 45.9% actually sought help. Females were more likely to identify a need for help, but no gender differences were observed in obtaining help after a need had been identified. Adolescents who first

turned to a family member or friend for support were twice as likely to receive professional help than those who did not, whilst nonwhite [*sic*], lower socio-economic status (SES) students were less likely to obtain help than their peers. Students with high levels of suicidal ideation were more likely to recognise a need for help, but were less likely to obtain help than those who had less severe or no suicidal ideation. Overall, this study demonstrated that adolescents "fall-off" at different steps along the help-seeking process, and whether they eventually receive help could be influenced by a number of factors, some of which will now be considered further.

Investigating psychological correlates of attitudes towards help-seeking in adolescents, Garland and Zigler (1994) examined the responses of 198 American high school students on the Help-Seeking Scale, the Children's Depression Inventory, the Revised Children's Attributional Style Questionnaire, and the Perceived Self-Efficacy Scale. Negative attitudes towards help-seeking were associated with male gender, adolescence, depressive symptomatology, and lower self-efficacy. Consistent with previous research, females had more positive attitudes towards help-seeking, as did younger adolescents. Adolescents who reported more depressive symptoms, and those with lower self-efficacy, were more likely to have negative attitudes about seeking help. This finding has important clinical implications in that adolescents at risk of depression are unlikely to seek help on their own accord and given the internalising nature of their symptoms, are also less likely to be identified as having a problem by others (Reynolds, 1994). This study is limited, however, in that it only addressed attitudes towards help-seeking and not actual help-seeking behaviour.

In comparison, Schonert-Reichl and Muller (1996) examined the demographic and psychological factors associated with seeking help for an emotional problem during early and middle adolescence. The participants were 221 adolescents aged from 13 to 18 years (M = 15 years). Each participant completed self-report measures

of help-seeking, self-worth, self-consciousness, and locus of control. Results showed that more female adolescents and middle adolescents sought help from friends, mothers, and professionals than did males and early adolescents. This is in contrast to the findings of Garland and Ziglar (1994), who reported more positive attitudes towards help-seeking in younger adolescents. Additionally, gender and locus of control were found to significantly discriminate between help-seekers and nonhelp-seekers; females with an internal locus of control sought help from their mothers, and females with an external locus of control sought help from friends. Adolescents who sought professional help reported lower self-worth, whilst adolescents who did not seek professional help were more self-conscious.

More recently, Sears (2004) examined 644 youths (Grades 7 to 12) in three rural communities of Canada. Participants completed a questionnaire assessing help-seeking behaviour, use of informal helpers, emotional adjustment, behavioural adjustment, and demographic characteristics. In total, 47% of these adolescents reported having experienced a serious problem in the past year, of which 15% perceived a need for professional help, with 7% having sought professional help. Adolescents who identified having a problem were more likely to be girls and to be living with someone other than a parent, were less likely to discuss problems with family members, and indicated more negative emotional and behavioural adjustment, including higher levels of depressive symptoms. Adolescents who perceived a need for professional help reported more negative emotional and behavioural adjustment, whilst youths who sought help were more likely to be older, were less likely to discuss their problems, and reported lower levels of anxiety than those who did not seek help.

In summary, the processes leading adolescents to seek help for mental health problems are complex. Clearly, a large proportion of adolescents do not seek help for

their psychological problems, “falling off” at various stages along the help-seeking pathway. Gender has been consistently linked to help-seeking, in that females are more likely to seek help and hold more positive attitudes towards help-seeking than males. Suicidality, depression, low SES, low self-efficacy, and self-consciousness have been identified as risk factors against seeking professional help. However, research specifically addressing the individual steps an adolescent must take to obtain professional help is lacking. In the next section, an additional aspect of adolescent help-seeking, namely, to whom adolescents turn for help, will be examined.

Studies to date suggest that adolescents prefer informal help sources over formal ones. For example, in an Australian study examining sources that adolescents turn to for help, Boldero and Fallon (1995) asked a school-aged sample (mean age = 14.47 years) of 1,013 adolescents to identify a problem which had caused them considerable distress over the previous 6 months. On a self-administered questionnaire, participants were asked to indicate the type of problem they were having, whether they had asked for help, and if so, from whom. Results demonstrated that just over half of the sample asked for help with their problem. Australian adolescents preferred to seek help from non-professionals (family, friends), followed by teachers, and other professionals (doctors, counsellors). Informal help-seeking differed as a function of gender, with males being less likely to ask for help from friends than females, and more likely to ask for help from parents. Older adolescents turned to peers more frequently for help, whilst younger adolescents were more likely to turn to family members. These findings indicate that whilst a large proportion of adolescents fail to seek help, those that do tend to rely on family or friends rather than seeking professional help.

Similar findings have also been reported elsewhere. For example, Offer, Howard, Schonert, and Ostrov (1991) examined the type of helping agents used by

adolescents for emotional problems and the perceived effectiveness of these helping agents. Participants were 497 adolescents from three metropolitan high schools in Midwest America. Participants completed the Offer Self-Image Questionnaire, the Delinquency Checklist, the Symptom Checklist, the Mental Health Utilization Questionnaire, the Adolescent Emotional Disturbance Assessment (AEDA) and a demographic questionnaire. Based on AEDA scores, 22% of the sample was defined as emotionally disturbed. For these adolescents, the most frequently used sources of formal help were school counsellors (40.5%) and mental health professionals (34. 2%). However, informal sources of help were far more popular, with 84% of emotionally disturbed adolescents reporting seeking help from a friend and 44% from a parent. Discussing problems with a friend was also perceived as being more beneficial by disturbed adolescents, which may be problematic if advice given by peers is not accurate. Adolescents appear to favour informal over formal sources of help; however, the factors influencing this preference deserve further attention.

Re-examining data from the previous study, Schonert-Reichl, Offer, and Howard (1995) investigated factors associated with adolescent help-seeking from formal and informal agents. With regards to gender, females were more likely to seek help from a mental health professional, and were also more likely to seek help from *both* formal and informal sources than males. Adolescents with a more positive self-image were more likely to seek help from their parents, whereas poorer self-image was related to seeking help from mental health professionals. Adolescents who sought help from both informal and formal sources tended to report more psychiatric symptoms, delinquent behaviours, and poorer grades than those who sought informal assistance alone. The authors suggested that adolescents who seek help from both informal and formal agents may do so through their parents' initiative, making the outcome of adolescents with internalising disorders uncertain, as parents who are not

aware of their child's distress or are not available to their child will not take action to seek help.

To summarise, whilst many adolescents never receive help for mental health problems, those that do tend to seek help from informal avenues, particularly peers and parents, rather than from formal or professional sources. If family or friends do not perceive the adolescent's problem as being serious, or are not equipped to deal with their difficulties, many adolescents with mental health problems may never access the professional care they require. Continuing the discussion of adolescent help-seeking, the next section will focus specifically on the help-seeking experiences of adolescents with depression, due to the added difficulties that these adolescents face in the help-seeking process.

Help-Seeking by Adolescents with Depression

Adolescents experiencing depressive symptoms or depressive disorders have been identified as being at a disadvantage in accessing mental health services (Wu et al., 1999). For adolescents suffering from depression, the very nature of depressive symptoms (e.g., withdrawal from others, feelings of hopelessness) in and of themselves may reduce the likelihood that they will actively seek help for their problems (Garland & Zigler, 1994). Furthermore, the internalising nature of depressive symptoms means that adolescents' symptoms are less readily identified, are often mistaken for other problem behaviours, or are considered to be a normal variation in adolescent development, thereby making depressed adolescents less likely to be referred for professional help than adolescents with other forms of psychopathology (Reynolds, 1994). In this section, research addressing the help-seeking pathways of adolescents with depression will be considered in order to

provide a fuller understanding of the difficulties faced by this population in accessing care.

Little is known about the help-seeking patterns of adolescents with depression, though the presence of depressive symptoms is thought to place these adolescents at a particular disadvantage in the help-seeking process (Garland & Zigler, 1994). Culp and Clyman (1995) examined depressed mood and help-seeking behaviour in a sample of American students (N = 220) from Grades 6 through 12. Students completed the CES-D and a questionnaire that solicited information regarding demographics, suicide attempts and suicidal ideation, awareness of counselling services, problems experienced by the student, their family, and friends, and how students cope with problems. Results indicated that 57% of students reported symptoms of depressed mood (CES-D scores $\geq$ 16), 33% reported experiencing suicidal thoughts, and 6% had attempted suicide. Among students with depressed mood, 49% did not seek help, of which, 68% believed they could take care of their problems themselves. These adolescents were over-represented among those reporting suicidal ideation. In addition, 45% of adolescents reported that they did not know what counselling services were available in their school. The help-seeking rates of adolescents with depression in this study are similar to those reported elsewhere (e.g., Saunders et al., 1994).

Investigating the psychosocial factors associated with help-seeking among adolescents with depression, Gasquet, Chavance, Ledoux, and Choquet (1997) surveyed 3,287 French students aged 12 to 20 years. Students completed a 280-item self-report questionnaire with sections pertaining to demographics, education, somatic and mental health symptoms, medication and substance use, lifestyle activities, help-seeking behaviour, and quality of family relationships. Fourteen percent of this sample had sought professional help for depression of which 8.4% had accessed

mental health services. Overall rates of depressive symptoms in this sample, however, were not reported. Severe emotional distress was found to be the best predictor of consultation for depressive symptoms. Additionally, females, older adolescents, adolescents from single-parent homes, adolescents with health concerns, and adolescents with high rates of school absenteeism were more likely to seek help for depression.

Examining the experience of mental health service use by adolescents with depression, Drauker (2005) conducted qualitative interviews with 52 young adults who were depressed as adolescents, 4 of their parents, and 7 professionals who worked with depressed adolescents. Using a grounded theory approach, common themes in mental health service use by adolescents were identified. Participants identified common "treatment pitfalls" or risks involved in use of mental health services. These included the belief that mental health clinicians would perceive the depressed adolescent to be "crazy", that disclosure of private information would not remain confidential, and that clinicians would not understand the adolescent's thoughts, feelings, or experiences. This study also characterised mental health service use as a process of "venturing through the system" whereby these pitfalls lead to avoidance of treatment, "holding back" in treatment, or allowing treatment to "take hold". Drauker concluded that mental health service use by adolescents with depression was a complex, fluid, and interactional process involving adolescents, parents, and mental health professionals, and recommended strategies be developed to avoid the pitfalls encountered by adolescents and their families. Whilst this study provided some insight into the experience of the help-seeking process for depressed adolescents and their families, research in this area remains limited and in need of further inquiry.

To summarise, little is known about the help-seeking experiences of adolescents with depression. Research to date suggests that at least half of adolescents with depression do not seek help, and many are unaware of the services available to them. Severe emotional distress, female gender, being older, being from a single-parent home, having other health concerns, and school absenteeism have been linked to help-seeking by depressed adolescents. In contrast, perceived stigma, concerns about confidentiality, and believing they will not be understood by professionals may act as barriers to depressed adolescents seeking help. Given the potential disadvantages depressed adolescents face in seeking professional help, further research is needed focussing on the help-seeking pathways of adolescents with depression to develop an understanding of the ways in which this service gap can be addressed.

In conclusion, studies examining the help-seeking pathways of adolescents provide the beginnings of an understanding of the large discrepancy between the number of teenagers suffering from a mental health problem and the number that access professional care. However, the pathways leading adolescents to seek help for mental health problems are clearly complex and multifaceted, and further research is needed before a clear picture of this process as it unfolds for adolescents can emerge. In particular, the experiences of adolescents with specific disorders, such as depression, and the circumstances of adolescents living in rural communities have been neglected, despite the added disadvantages these adolescents face in accessing professional help. Whilst many elements of adolescent help-seeking remain unclear, it is well established that a large proportion of adolescents do not seek help for a psychological problem on their own accord. As such, we will turn our attention now to parent-mediated pathways to professional care for adolescents.

Parent-Mediated Pathways to Help-Seeking

An emerging area of research in understanding the help-seeking pathways of adolescents is recognition of the role that others play in this process. Clearly, many adolescents do not seek help on their own (Dubow et al., 1990; Rickwood & Braithwaite, 1994; Saunders et al., 1994), and may require assistance from other people (e.g., parents, relatives, teachers, peers) to facilitate their pathway to mental health care. In this section, consideration will be given to the influence of others over the help-seeking process of adolescents with mental health problems, before focussing specifically on the role of parents. As part of this, a parent-mediated model of help-seeking will be presented, following which the scarce research in the area of parent mediated pathways to care for adolescents with mental health problems will be reviewed.

To gain a better understanding of the help-seeking process as it unfolds for young people, it has been recommended that traditional adult-based help-seeking models be revised to take into account the unique developmental issues of adolescence (Costello et al., 1998). As previously mentioned, adolescence marks a time of increasing autonomy and individuation; however, adolescents are also highly susceptible to systemic influences such as parents, family, schools, and the broader community during this stage of development (Hartos & Power, 1997; Logan & King, 2001). Traditional help-seeking models focus largely on the individual as the determining agent in their pathway to care (Cauce et al., 2002) with less attention given to the influence of outside forces on the help-seeking process. Whilst some adolescents negotiate help-seeking pathways independently, many adolescents require the assistance of others to facilitate the complex process of seeking and obtaining professional help (Logan & King, 2001).

In line with this, Fröjd, Marttunen, Pelkonen, von der Pahlen, and Kaltiala-Heino (2007) proposed a model of adolescent help-seeking to include members of adolescents' social networks. A prospective follow-up design was employed with 3,725 Grade 9 Finnish students (mean age = 15.5 years) assessed at Time 1 (T1), of which 2,080 (mean age = 17.6 years) participated at two-year follow-up (T2). To assess depressive symptoms, a Finnish version of the Beck Depression Inventory was completed by adolescents at T1 and T2. At follow-up, adolescents also completed a questionnaire asking about perceived need for help for depression or another mental health problem, past use of professional services for depression or another mental health problem, whether others had been concerned about changes in their mood/behaviour (i.e., mother, father, sibling, peers, boy/girlfriend, teacher), and current family structure. Results showed that of those adolescents meeting the criteria for depression at T1 only 23% reported having sought professional help at T2. With regards to the influence of social networks on adolescents receiving help, having depression at T1 was significantly associated with reports at follow-up that parents and significant others had been concerned about changes in the adolescent's mood or behaviour, whilst concerns of the mother, peers, and teacher were significantly associated with help-seeking for depression. Whilst the large sample and follow-up design are strengths of this study, these findings are limited in that perceived concern of others for the adolescent were based solely on adolescents' reports, rather than direct reports from those within adolescents social networks. It is therefore unclear as to the accuracy of adolescents' perceptions of others' concerns and may be better assessed directly through these sources rather than from adolescents alone.

Addressing this, Zwaanswijk, van der Ende, Verhaak, Bensing, and Verhulst (2007) proposed a model to examine the different stages and actors involved in the process of seeking help from mental health services for adolescents. Through the use

of structural equation modelling, the model was tested on a sample of 114 Dutch adolescents (aged 12 to 17 years) who were identified as having emotional or behavioural problems (i.e., scoring within the deviant range on the Teacher Report Form, CBCL, or YSR Total Problems Scale). Adolescent and parent perceptions of the need to access services were assessed using the DISC-IV, the DISC-Parent Version (DISC-P), and the DISC-Youth Version (DISC-Y), and interviews with parents were undertaken to assess the type of help sought (i.e., GPs, mental health care professionals, teachers, family, or friends). Of this sample, only 16.5% of adolescents had accessed mental health services in the last 12 months. With regards to the help-seeking process, results showed positive associations between adolescent and parent reporting of problems and service need, such that adolescent recognition and parent recognition of problems both influenced whether a need for professional help was perceived. Teachers were found to play a limited role, with teacher perception of problems not affecting perceived need for services. Of the adolescents who accessed mental health services, the majority (61.1%) were referred by their GP with GPs being seen as 'gatekeepers' to mental health care for Dutch adolescents. However, this study did not focus on depression specifically and was limited to a Dutch sample and system of care, making it unclear as to whether these findings would match the experiences of Australian adolescents with depression.

Findings from both of these studies support the need for consideration of the role of others in the help-seeking process of adolescents with depression. Whilst findings regarding the role of some support networks (e.g., peers and teachers) were inconsistent, both studies identified parents as playing an important role in this process. Given that assistance from others may be a determining factor in whether adolescents access mental health services, and that parents have been identified as being in a position to play a central role in facilitating this process (Costello et al.,

1998; Logan & King, 2001), attention will now be given to the specific role that parents play in assisting adolescents to seek help.

Addressing the role of parents in adolescent help-seeking, Logan and King (2001) proposed a parent-mediated model of pathways to service use for adolescents. This model depicts the multiple steps that parents must take in order to access mental health services for their child. Parents must first (a) come to be aware of their adolescent's distress, and then (b) recognise that the problem is psychological in nature. Once recognised, parents have to (c) consider what options are available for helping their teenager, from which (d) an intention to seek mental health services develops. Finally, (e) parents will make an active attempt to seek out services, leading to (f) their adolescent obtaining psychological help. At each stage along this process various characteristics of the parent, the child, and the larger social system in which they are embedded will act to either enable or inhibit progress towards the ultimate outcome of mental health service use (Costello et al., 1998; Logan & King, 2001; Zwaanswijk et al., 2007). Whilst this approach is compelling, very little research has been conducted examining the role of parents in the help-seeking process for adolescents, or the factors that may impinge upon this process.

Regardless of the objective severity of an adolescent's problems, it has been argued that it is the *parent's perception* of their adolescent's behaviour as being problematic that will determine whether they initiate help-seeking for their teenager (Fröjd et al., 2007; Morrissey-Kane & Prinz, 1999). Moreover, whether the parent perceives their child as having a problem that requires help will be largely influenced by the amount of burden the parent experiences as a result of their adolescent's difficulties (Angold et al., 1998; Farmer & Burns, 1997; Logan & King, 2001). Sources of burden for parents include demographic factors that contribute to isolation or restrict access to resources (e.g., poverty, rurality), "stress-and-strain" (e.g.,

negative life events, parental psychopathology, parent-child relationship problems, family problems), severity of the adolescent's psychopathology, and nature of the disorder (e.g., externalising versus internalising; Angold et al., 1998).

Exploring the impact of perceived parental burden on help-seeking, Angold et al. (1998) employed data from the Great Smoky Mountains Study (GSMS) of child and adolescent mental health utilisation. A representative sample of 9-, 11-, and 13-year-olds (n = 4,500) from public schools in a predominantly rural region of the United States were screened and those likely to meet the criteria for a *DSM-III-R* diagnosis were recruited into the study (n = 1,015). Children and primary caregivers were interviewed separately using the Child and Adolescent Psychiatric Assessment and the Child and Adolescent Services Assessment, and parents completed the Child and Adolescent Burden Assessment. Results showed that 10.7% of parents experienced some degree of burden from their child's psychiatric symptomatology, and that perceived burden was the strongest predictor of service use. Significant predictors of perceived burden were levels of child symptomatology and impairment as well as parental psychopathology. Children's depressive and anxiety disorders were associated with fewer burdens than other diagnoses, in turn suggesting that parents of these children would be less likely to seek help for their child's difficulties. However, this study did not examine adolescents specifically or consider at which stage along the help-seeking pathway parental burden exerts its effects.

Another factor which may influence whether or not parents seek help for their child's psychological problems is the effects that such actions would have on parents' feelings of self worth (Raviv, Raviv, Edelstein-Dolev, & Silberstein, 2003; Raviv, Raviv, Propper, & Schachter Fink, 2003). There is little doubt that a certain level of stigma is attached to seeking help for psychological problems (Barney, Griffiths, Jorm, & Christensen, 2006; Crisp, Gelder, Rix, Meltzer, & Rowlands, 2000) with

public perceptions for initiating mental health consultation set at a much higher threshold of severity than for general medical/health conditions (Costello et al., 1998). Adding to this, seeking help for their adolescent's problems may lead parents to experience feelings of inadequacy or incompetence in their role as caregivers (Costello et al., 1998; Raviv, Raviv, Edelstein-Dolev, et al., 2003). If this threat exceeds the perceived benefits of accessing care for their child, parents may not initiate the help-seeking process (Raviv, Raviv, Edelstein-Dolev, et al., 2003).

Addressing this issue, Raviv, Raviv, Edelstein-Dolev, et al. (2003) examined the difference between mothers' reported willingness to seek psychological help for their own child and their willingness to refer another mother for such help. Participants were 321 mothers of 3rd to 5th grade school children sampled from four elementary schools in Israel. Each participant received a questionnaire describing a scenario of a child the same age as their own that was experiencing either an externalising or internalising problem. In one condition mothers were asked to imagine that the scenario was describing their own child (self-referral), whilst in the second condition they were asked to imagine that the scenario was describing a child of a friend (other-referral). Participants then answered a series of questions regarding their emotional response, causal attributions, socialisation strategies, and willingness to seek help in relation to the scenario. The main finding of this study was that mothers were more willing to refer someone else's child to a psychologist than their own. The authors interpreted this finding as indicating that referring someone else's child for help incurs less threat to self-esteem than referring one's own; however, threat to parents' self-esteem was not systematically tested in this study and can only be inferred.

In summary, a number of factors have been identified which may either facilitate or act as barriers to parents seeking help for their adolescents' psychological

problems. Burden experienced by parents as a result of their child's difficulties may encourage parents to seek out mental health services for their teenagers. However, children suffering from disorders that place fewer burdens upon parents, such as depression, may be less likely to receive professional help than those with disruptive behaviour disorders. Seeking help for their child may also lead to feelings of inadequacy for parents. Such threats to self-esteem may inhibit parents from seeking psychological help for their child; however, this assertion has yet to be systematically tested. Another aspect of the help-seeking process worthy of consideration is the source of help to which parents turn on behalf of their adolescents.

Whilst it has been suggested that parents may be more likely to take the initiative to seek mental health services on behalf of their adolescent than adolescents themselves (Logan & King, 2001), research in this area is lacking. Raviv, Maddy-Weitzman, and Raviv (1992) examined intentions of parents of adolescents to seek help from various sources for hypothetical parenting problems. Participants included 187 parents of adolescents, aged 16 to 17 years, from two high schools in Israel. Parents completed a questionnaire which examined help-seeking from nine different sources on eight hypothetical parenting issues (communication, values, independence, sex, school studies, mood, social problems, and drugs). Results demonstrated that intention to seek help was a function of both the problem type and the potential source of help. Parents intended to seek help from a variety of sources, with spouses being the most common. In terms of professional help, parents relied on this avenue to a moderate degree and were most likely to seek professional help when the problem was considered to be serious and in the professional's area of expertise. Additionally, parents with a higher education level were more likely to seek help from a psychologist than lower educated parents. Whilst parents intended to seek help from a variety of sources, including psychologists, these findings are limited in the present

context as this study did not address help-seeking for adolescent psychopathology but, rather, parenting issues in general.

Examining help-seeking preferences of parents in the United Arab Emirates, Eapen and Ghubash (2004) interviewed a community sample of 329 parents (156 mothers, 169 fathers) regarding their attitudes and preferences for seeking help for mental health problems of their children. Results showed that 37% of parents would seek help from a mental health specialist if a member of their family (including children) was experiencing psychiatric problems. Reasons given for not seeking professional help included a reluctance to acknowledge a family member has a mental illness, stigma associated with mental health service use, and scepticism about the usefulness of mental health services, whilst seeking help was associated with higher education, occupation, and SES. The ages of the participants' children, however, were not reported, and it is, therefore, unknown as to whether parents of adolescents were included in the sample. Also, given cultural differences between the United Arab Emirates and Australia, it is difficult to determine how applicable these findings would be to parents of Australian adolescents.

To summarise, research in this area to date is insufficient to draw any conclusions regarding the sources that parents turn to for help when their adolescent is experiencing a mental health problem. Parent's level of formal education does appear to be linked to seeking help from mental health service providers, such that parents with a higher level of education are more amenable to seeking professional psychological help for their child. However, findings regarding the sources of help that parents seek for adolescent psychopathology remain limited and further research is warranted, particularly using an Australian sample. In the next section, research addressing the process of parent-mediated pathways to care for adolescents with

mental health problems, at the point of problem recognition and beyond, will be reviewed.

To date, research on the role of parents at various steps along the help-seeking pathway for adolescents is scarce. However, studies are beginning to emerge which address the function of parental involvement in the preliminary steps in the help-seeking process; namely, awareness and recognition of adolescent problems. Parental recognition is considered to be an essential component of any parent-mediated pathway to care (Costello et al., 1998). Without recognising that their adolescent is experiencing a problem, parents are unlikely to initiate any help-seeking action on their teenager's behalf (Broadhurst, 2003; Costello et al., 1998; Logan & King, 2002).

To examine mothers' awareness of their adolescents' stressors, Hartos and Power (1997) recruited 161 adolescent-mother pairs from ninth grade classes in an American high school. Adolescent perceived stress was measured via the Inventory of High School Students' Recent Life Experiences (IHSSRLE), whilst a modified version of the IHSSRLE was used to assess mothers' knowledge of their adolescents' stressors. Parent-adolescent communication was also assessed via the Parent-Adolescent Communication Scales, and problem behaviours were measured using the Anxious/Depressed and Aggressive subscales of the CBCL and the YSR. Findings indicated that mothers were only minimally aware of their adolescents' stressors, with adolescents reporting experiencing more stressors than did their mothers. Parent-adolescent communication was inversely related to adolescent problem behaviours, and positively correlated with mothers' awareness of adolescents' stressors. Thus, adolescents whose mothers were more aware of their teenager's stressors reported better parent-adolescent communication and less problem behaviours. However, these findings must be interpreted with caution given the correlational nature of the study.

Also, this study was limited in that it did not address help-seeking beyond parental awareness.

Addressing the effects of parental problem recognition on mental health service use, Teagle (2002) employed the same data set from the GSMS as previously described in Angold et al.'s (1998) study. Further analysis of this data revealed that only 39% of parents of children with one or more psychiatric diagnoses perceived their child as having a problem and only 31.7% perceived any burden. Perceiving problems and burden was highest among parents of children with attention-deficit/hyperactivity disorder, followed by children with a depressive disorder. Parents of younger children were more likely to perceive problems than parents of adolescents, whilst parents of older children were more likely to perceive family burden than parents of younger children. In relation to help-seeking, problem recognition was a strong predictor of mental health service use for these children. These findings indicate that many parents do not recognise that their child is experiencing a psychological problem, particularly for adolescents, and this could lead to a failure to access mental health services.

Problem recognition is thought to present an even greater challenge for parents in the case of adolescent depression, given the internalising nature of depressive symptoms (Logan & King, 2002). Assessing parental identification of adolescent depression and mental health service use, Logan and King (2002) recruited 44 adolescents with depressive disorders (aged 12 to 18 years). Participants were first screened for depression in a paediatric outpatient clinic and then invited for further evaluation if presenting with signs of possible depression. Adolescents meeting the diagnostic criteria for a depressive disorder and their parents then completed measures of problem identification, service utilisation, perceived burden, adolescent-parent communication, and parental depression. Results showed that overall parents were

poor at recognising symptoms of depression. Seventy-nine percent of parents failed to endorse a single depressive symptom on the DISC, and only 11.4% reported sufficient symptoms to meet the diagnostic criteria for a depressive disorder. When depression was conceptualised dimensionally rather than diagnostically using the Child and Adolescent Functional Assessment (CAFAS) Moods/Emotion subscale, 43.2% of parents endorsed items sufficient to make a rating of moderate to severe mood/emotional impairment. In relation to service use, 50% of parents had sought help from a non-mental health professional for their adolescent's problems, whilst 35% had made contact with a mental health specialist in the last year. Additionally, parental perception of family burden was the strongest predictor of depression identification by parents, and this relationship was postulated to mediate mental health service use. Adolescent-parent communication and parental depression, however, were not associated with parental identification of depression or mental health service use. This finding regarding parental depression is in contrast to past research suggesting that parental psychopathology and past psychological treatment of parents or relatives are predictors of problem recognition and help-seeking (Zwaanswijk et al., 2003). Logan and King concluded that parental identification of depression appears to be important in facilitating pathways to mental health services for adolescents; however, future studies need to extend beyond the initial step of recognition to consider other stages in the help-seeking process.

Overall, parents are in the position to play a key role in facilitating the help-seeking process for adolescents, which in turn may aid in bridging the gap between adolescent psychopathology and mental health service use. However, findings to date regarding parent-mediated pathways to care remain quite limited. Research suggests that, like adolescents, certain factors may impinge upon parents' decisions to seek help for their child. Research also suggests that the source of help that parents turn to

on their child's behalf may vary. The role that parents play at various steps along the help-seeking process is still largely unknown, although recent research suggests that parents may not be aware of their adolescents' problems and may be poor at identifying adolescents' mental health symptoms. As such, many adolescents may "fall-off" the help-seeking pathway at the first step in the help-seeking process. To extend on these findings, future research is needed to examine parent-mediated pathways beyond initial identification in order to provide a fuller account of the role parents play in helping an adolescent child with depression to access mental health services.

Summary of the Literature

Early and effective treatment is critical in minimising the negative outcomes associated with psychological disorders that occur during adolescence. However, research to date indicates a large gap between the incidence of psychological disorders among adolescents and the number of adolescents who receive treatment from mental health service providers. Furthermore, a significant proportion of adolescents do not seek help for psychological problems on their own accord, dropping out at various stages along the help-seeking pathway.

A review of the literature suggests that adolescents with depression and those living in rural communities face a particular disadvantage in the help-seeking process. The very presence of depressive symptoms, such as hopelessness and withdrawal, may prevent adolescents from actively seeking help for themselves. Furthermore, the internalising nature of depressive symptoms means they are less likely to come to the attention of others or may be misinterpreted as normal variations in adolescent development. For adolescents residing in rural areas, the geographical, social,

cultural, economical, and political characteristics of rural places may act as additional barriers to obtaining help for a psychological problem.

Parents are an important source of help to adolescents and their contribution to the help-seeking process may aid in bridging the gap between adolescent psychopathology and mental health service use. By playing a facilitatory role, parents are in the position to assist their teenager in receiving professional treatment that they may not access if left to their own devices. This may be particularly beneficial in the case of adolescents with depression and those living in rural communities, who face additional barriers to mental health care. However, the role that parents play on their child's behalf at various steps along the help-seeking process remains relatively neglected in the literature. Preliminary evidence indicates that a parent's ability to identify a child as having a mental health problem is an important first step in accessing professional care (Logan & King, 2002); however, further research is needed to examine parent-mediated pathways to mental health care for adolescents beyond initial recognition of the problem.

To investigate the potential facilitatory role for rural parents in assisting an adolescent with depression to seek mental health care in a rural context, research is needed to examine the ability of a representative sample of rural parents to identify depressive symptoms. Whilst previous research has investigated whether mothers of depressed children can recognise their child's symptoms, no study has examined the ability of parents whose child *has not* been formerly diagnosed with a depressive disorder. By gauging the "average" parent's ability to identify adolescent depressive symptoms and describe their intended course of action for such a problem, a more comprehensive understanding of the potential that parent-mediated pathways to care hold in improving mental health service utilisation rates for rural adolescents with depression would be provided.

Also, whilst a theoretical framework of parental help-seeking has been proposed, research has yet to examine its practical application in a rural or regional context. That is, very little is known about the "real-life" experiences of parents residing in regional areas who *have* sought help for their children. To gain a fuller understanding of how parental-mediated pathways to care unfold in a rural context, it would be useful to examine the steps that parents have *actually* taken to obtain professional help for their teenagers.

The Present Study

The present study was designed to make a significant contribution to the literature by examining the role that parents play in facilitating pathways to care for rural adolescents with depression. This line of inquiry is important for a number of reasons. Firstly, depression represents a significant mental health problem for the adolescent population that can lead to a number of potentially damaging consequences. Therefore, seeking early and effective treatment is essential to minimise the negative outcomes associated with this mental health problem. Secondly, many adolescents do not seek help for psychological problems of their own accord, decreasing their opportunities of receiving appropriate treatment. Thirdly, rural adolescents with depression face additional barriers to seeking help. They are therefore even less likely to receive treatment, and as a consequence, are at a greater risk of poor outcomes. Finally, parents are in the position to play a key facilitatory role in the help-seeking process. If shown to be an effective means to helping adolescents access care, encouraging parental involvement may enable rural adolescents with depression to receive much needed treatment sooner, and therefore improve their chances of recovery.

To examine the role of parents in the help-seeking process, this study was conducted in two parts. In Study 1, the ability of parents of rural adolescents to identify symptoms of depression was examined. Extending beyond initial problem recognition, Study 1 also investigated the help-seeking intentions of parents when presented with descriptions of adolescents exhibiting depressive symptoms, including the types of help that parents would turn to and factors that predict parents' intentions to seek help.

Chapter 2: Study 1

The aims of Study 1 are to determine whether parents of rural adolescents are able to identify the nature and severity of depressive symptoms among adolescents, thereby addressing the initial stage of the help-seeking process. Also, this study aims to extend beyond the initial stage of problem recognition by investigating the help-seeking intentions of parents of rural adolescents once a problem has been identified, including exploring their preferred sources of help and factors that predict parents' help-seeking intentions.

It was hypothesised that when presented with a series of hypothetical scenarios in which descriptions of adolescents with depression are depicted, parents of rural adolescents will be able to (a) correctly identify depression, (b) correctly identify the level of severity, and (c) identify a need for help at rates higher than those expected due to chance alone. Also, it was hypothesised that parents would be more likely to refer a hypothetical adolescent for help than if their own child was experiencing a similar problem. In addition to these hypotheses, a series of exploratory analyses will be conducted to determine the best predictors of help-seeking according to the severity of the problem.

Method

Participants

A voluntary sample of 304 parents of adolescents living in rural and regional areas of Victoria, Australia, took part in this study. Participants were parents of adolescents attending Victorian Government schools in the Grampians and Loddon Mallee regions of the state. In total, 18 schools from the Grampians region and 15 schools from the Loddon Mallee region were contacted and invited to take part in the

study. Of the schools contacted, 7 schools from the Grampians Region and 8 schools from the Loddon Mallee region agreed to participate. Participating schools consisted of 5 secondary schools and 10 P-12 (combined primary and secondary) schools.

To obtain a representative sample of rural/regional Victoria, schools were sampled across a range of Accessibility/Remoteness Index of Australia (ARIA+; National Key Centre for Social Applications of Geographical Information Systems [GISCA], 2006) and Socio-Economic Indexes for Areas 2001 (SEIFA 2001; Australian Bureau of Statistics [ABS], 2003) scores (see Appendices A and B for details of ARIA+ and SEIFA 2001 indices). ARIA+ index scores for the 15 schools sampled according to postcode ranged from .21 to 7.7, with a mean of 4.05 (*SD* = 1.74). Twelve (80%) of the schools were from areas classified as Outer Regional Australia, 2 (13.33%) were classified as Inner Regional Australia, and 1 (6.67%) was classified as Remote Australia. SEIFA 2001 scores on the Index of Relative Socio-Economic Advantage/Disadvantage of participating schools ranged from 877.078 to 992.643, with a mean score of 940.263 (*SD* = 26.223).

The sample referred to as *parents*, consisted of mothers 88.8% (*n* = 270), fathers 10.5% (*n* = 32), and guardians 0.7% (*n* = 2). Ages of parents ranged from 31 to 71 years, with a mean age of 44.32 years (*SD* = 5.40). Highest educational levels attained by this sample of parents were tertiary 33.8% (*n* = 102), secondary 43% (*n* = 130), and 33.8% (*n* = 70) indicated that they did not complete secondary school. In regards to marital status, 85.5% (*n* = 260) of parents were married, 4.6% divorced (*n* = 14), 3% single (*n* = 9), 3.6% defacto (*n* = 11), 2% widowed (*n* = 6), and 1.3% (*n* = 4) indicated 'other' marital status. Ten percent (*n* = 30) of parents indicated that they themselves had experienced a psychological/mental health problem of which 80% (*n* = 24) reported having sought professional psychological help for this problem.

Ages of the target adolescents (i.e., those that took questionnaires home) ranged from 12 to 18 years, with a mean age of 14.88 years (*SD* = 1.63). The gender distribution of target adolescents was relatively even with males 46.7% (*n* = 142) and females 53.3% (*n* = 162).

Materials

Demographics questionnaire. A brief 10-item form was designed to gather demographic information from participants (see Appendix C). Items included age of parent, age of child, relationship to child, parent's education level, parent's marital status, parent's occupation, parent and child history of mental health problems, and whether parents had previous experience in seeking professional psychological help for their own or their child's mental health problem.

Parent Help-Seeking Questionnaire (PHSQ). The PHSQ was developed by the student researcher specifically for the purposes of this research. The purpose of this questionnaire was to assess the ability of parents to identify the symptoms of depression in adolescents and to examine their help-seeking intentions when presented with such a problem. No such instrument previously existed.

The PHSQ is a 21-item self-report questionnaire (see Appendix D). It consists of two versions, male and female, with each containing three hypothetical scenarios describing an adolescent boy or girl experiencing one of three problems. The content of the scenarios are identical across the male and female versions, apart from the name of the adolescent (e.g., Hayley/Adam, Jess/Jack, Emma/Ryan) and the use of male or female pronouns (e.g., his/her, he/she). Scenario 1 (mild) describes an adolescent who is experiencing difficulty adjusting to a recent life event (i.e., a relationship break-up), Scenario 2 (moderate) describes an adolescent who is exhibiting symptoms consistent with a DSM-IV-TR diagnosis of dysthymic disorder,

and Scenario 3 (severe) describes an adolescent who is exhibiting symptoms consistent with a DSM-IV-TR diagnosis of a major depressive episode. Only symptoms that would be directly observable to parents were used in the scenarios, in an endeavour to simulate the situation parents might face when trying to identify depression in the natural setting.

Item 1 is an open-ended question requiring participants to make a judgement about the type of problem the adolescent depicted in the scenario is experiencing. Responses to this item were coded into one of five possible categories, as presented in Table 3.

Table 3

Coding Categories and Example Responses for Item 1 on the PHSQ

Category	Example Responses
1. Depression	"depression", "depressed and withdrawn", "severe depression", "long term depression"
2. Depression + other clinical/subclinical issues	"depression or using drugs", "he may be suffering from depression, bulimia, or schizophrenia", "depression, eating disorder, drugs", "depression – low self esteem", "angry, depressed", "stressed, depressed, low self esteem", "depression, bullying at school"
3. Clinical issue, excluding depression	"eating disorder", "substance abuse", "drug use", "agoraphobia", "anxiety or experimenting with drugs"
4. Subclinical issue	"low self esteem", "bullying", "lack of identity", "stressed"
5. Nonclinical issue	"normal broken heart", "disappointment", "body changes, hormones", "difficulty with school work", "normal moody teenager", "mood swings", "boredom", "growing up", "medical/health problem"

Item 2 in the PHSQ required parents to rate the level of severity of the problem from three options (i.e., mild, moderate, severe). For items 3 and 4 respectively, parents were asked to indicate whether they believed the adolescent in the scenario required help to manage their problem (e.g., yes/no), and to select appropriate sources of help for that adolescent from 10 available options (i.e., parents, other adult relative, friend, psychologist, school counsellor, teacher, doctor, psychiatrist, religious minister, school nurse). Items 5 and 6 required parents to, firstly, indicate whether they would seek help for their own son/daughter if they were experiencing a problem similar to the adolescent depicted (e.g., yes/no), and secondly, to select the sources of help they would turn to from a list of 10 options (i.e., spouse/partner, other adult relative, friend, psychologist, school counsellor, teacher, doctor, psychiatrist, religious minister, school nurse). Finally, item 7 required parents to respond on a 5-point Likert scale ranging from *not at all likely* to *very likely,* regarding the likelihood that they would seek help from the sources listed in item 6 for their own son/daughter if they were experiencing a problem similar to the adolescent described.

To address the possibility of order effects, the three scenarios and corresponding questions were counterbalanced (e.g., 123, 132, 213, 231, 321, 312), creating 12 versions (6 male, 6 female) in total.

Procedure

Ethical approval was sought from the University of Ballarat's Human Research Ethics Committee (see Appendices E and F) and the Victorian Department of Education and Training's (DE&T) Ethics Committee (see Appendix G) prior to commencement of this research. Following ethical approval, contact details of Victorian Government secondary schools in the Grampians and Loddon Mallee

regions were obtained from the DE&T website. Letters outlining the nature and aims of the research were sent to the principals of 33 schools within these regions, inviting their school to participate (see Appendix H). Two weeks later, follow-up phone calls were made to each school principal to confirm whether or not their school would be willing to take part.

Schools agreeing to participate were mailed parcels containing one questionnaire package per family enrolled, a short written description of the research project for use in school newsletters (see Appendix I), and a letter with guidelines on how to distribute questionnaire packages (see Appendix J). In this letter, schools were instructed to send home one questionnaire package per family with students from years 7 to 12. Only parents of students from years 7 to 12 were asked to complete questionnaires, given the study's focus on *adolescent* problems. Questionnaire packages were coded with coloured dot stickers according to the version (male or female) of PHSQ contained in them. Schools were instructed to distribute packages with a blue dot sticker to male students and red dot sticker to female students, to ensure that questionnaire packages matched the gender of the target adolescent. Once distributed, students were asked to take the questionnaire packages home for one of their parents to complete.

In total, 1494 questionnaire packages were distributed to participating schools. These packages consisted of an A4 envelope containing a plain language statement (see Appendix K), demographic questionnaire, PHSQ, and a reply paid envelope. Outlined in the plain language statement were the nature and aims of the research, what participation would involve, that participation was voluntary, and the exclusionary criteria (i.e., parents who have previous experience seeking professional help for their child). Parents who had previous experience in seeking professional help for a child/adolescent with a mental health problem were excluded from this

study, as this study aimed to examine the 'hypothetical' intentions of parents who *did not* have previous help-seeking experience. Including parents who had previous experience in seeking help for a child with a mental health problem may have led to bias, whereby such parents may have responded with 'actual' rather than 'hypothetical' answers on the PHSQ.

Participants meeting the exclusionary criteria were informed that they need not complete the questionnaire and to please disregard it. Parents meeting the inclusion criteria were asked to complete the questionnaires and return to the researcher in the reply paid envelope provided. Completion and returning of the questionnaires was taken to imply consent on participants' behalves.

Three-hundred-and-sixteen questionnaires were completed and returned to the researcher, resulting in a response rate of 21%. Of these, 2 questionnaires were excluded as the child's age was listed as being less than 12 years (i.e., not an adolescent), and 10 questionnaires were excluded as the parent indicated that they had previous experience in seeking professional psychological help for their child. This left a total sample of 304 participants.

Results

Analytic Plan

In Part 1 of the results section, the psychometric properties of the PHSQ will be examined, including inter-rater reliability, factor analysis of help-seeking options, and internal consistency of the three subscales derived for each scenario from factor analysis.

In Part 2 of the results section, parents' identification of the problem type and severity as well as their intentions to seek help will be examined for each of the three

scenarios. This will include the examination of frequency data and nonparametric testing using the chi square goodness-of-fit test and chi-square test of independence.

Finally in Part 3, predictors of parents' help-seeking intentions will be examined, beginning with preliminary analysis and assumptions testing, followed by multiple regression for continuous dependent variables and logistic regression for dichotomous dependent variables.

Part 1: Psychometric Properties of the PHSQ

Inter-Rater Reliability

Clinician ratings of the scenarios were obtained from six practising psychologists who were naïve to the aims of this research (see Appendix L). For Scenario 1 (mild), three (50%) clinicians rated the scenario as not being clinically significant, whilst the remaining three rated the scenario as depicting adjustment disorder. Whilst only half of clinicians agreed on this rating, it was considered adequate given that the focus of this study was on parents' ability to identify depression and differentiate it from other clinical/nonclinical issues. For Scenario 2, four clinicians (67%) indicated that the scenario depicted dysthymic disorder, with the remaining clinicians identifying it as a form of depression or mood disorder. Five of the clinicians (83%) rated Scenario 3 as a major depressive episode or major depressive disorder, whilst the remaining clinician rated it as depression. Clinician ratings for Scenario 2 and 3 were considered adequate, given that the purpose of these scenarios was to determine parents' ability to identify depression or depressive symptoms, and there would not be an expectation that parents be able to identify the specific mood disorder (e.g., major depressive disorder, dysthymic disorder).

Inter-rater reliability was also obtained for coding of responses to Item 1 (i.e., what type of problem is the adolescent in the scenario experiencing?) for each

scenario. Twenty percent (n = 61) of questionnaires were randomly selected and scored independently by the author and a colleague, establishing an agreement rate of 84%. Consensus rates of 70% or greater are recommended to ensure reliability (Stemler, 2004); therefore, this was considered adequate.

Principal Components Analysis

Principal components analyses with varimax rotation were conducted to examine whether the help-seeking options listed in Item 7 on the PHSQ could be reduced into categories reflecting broader types of help. Varimax rotation was chosen as the PHSQ is a new measure and the analyses exploratory. The likelihood of parents seeking help from 10 possible options (spouse/partner, doctor, friend, psychologist, teacher, school counsellor, psychiatrist, other adult relative, religious minister, school nurse) were factor analysed for each of the three scenarios in the PHSQ.

Prior to commencement of the analyses, the data were screened to determine their suitability for PCA. Inspection of the correlation matrix revealed multiple coefficients of .3 or above for each of the three scenarios. All Kaiser-Meyer-Olkin values were above the recommended value of .6 (Tabachnick & Fidell, 2007) at .79, .68, and .71 for scenarios one, two, and three respectively. Bartlett's Test of Sphericity was significant for all three scenarios, supporting the factorability of the correlation matrix (Pallant, 2005).

For all three scenarios, examination of the factor scree plots suggested a three factor solution within each scenario. In accordance with the Kaiser criterion (Pallant, 2005), three factors with eigenvalues exceeding one were identified for each of the scenarios. These three factor solutions accounted for 65%, 57%, and 59% of the variance for scenarios one, two, and three respectively. Results of these analyses are presented in Tables 4, 5, and 6.

Table 4

Varimax-Rotated Factor Loadings for Item 7 (Scenario 1-Mild) of the PHSQ

	Factor		
Source of help	1	2	3
Psychologist	.86		
Psychiatrist	.84		
Doctor	.78		
Religious minister	.44	.41	
School counsellor		.82	
Teacher		.77	
School nurse	.33	.77	
Friend			.84
Other adult relative		.34	.71
Spouse/partner			.66

As can be seen in the Tables 4 through 6, the ten sources of help listed in Item 7 tended to load on separate factors for all three scenarios. One factor included professional sources of help (psychologist, psychiatrist, doctor), a second factor comprised largely of school-based sources of help (teacher, school counsellor, school

nurse, religious minister), and the third factor included informal sources of help (friend, other adult relative, spouse/partner). Although 'religious minister' loaded on both Factor 1 and 2, an analytic decision was made to include it in Factor 2 to separate it from mental health professionals and place it within school-based help. Thus, three subscale scores – professional help, school-based help, and informal sources of help – were created for each scenario. These subscales were used in all further analyses.

Table 5

Varimax-Rotated Factor Loadings for Item 7 (Scenario 2-Moderate) of the PHSQ

	Factor		
Source of help	1	2	3
Psychiatrist	.85		
Psychologist	.84		
Doctor	.69		
School nurse		.74	
School counsellor		.74	
Teacher		.73	
Religious minister		.40	
Friend			.88
Other adult relative			.81
Spouse/partner			.50

Table 6

Varimax-Rotated Factor Loadings for Item 7 (Scenario 3-Severe) of the PHSQ

	Factor		
Source of help	1	2	3
School counsellor	.77		
School nurse	.77		
Teacher	.66		.35
Religious minister	.45		
Psychologist		.82	
Psychiatrist		.80	
Doctor		.77	
Friend			.80
Other adult relative			.76
Spouse/partner			.66

Internal Consistency of the PHSQ

As the PHSQ is a new measure and reliability had not yet been established, alpha coefficients were obtained for each of the nine subscales scores. The internal consistency (Cronbach's alpha) of the nine subscales are presented in Table 7. Whilst alpha levels above .7 are recommended to ensure reliability (Francis, 2001), it has been proposed that lower levels are acceptable for scales with a small number of items (Michelson & Mavissakalian, 1983). Given the small number of items comprising each factor, all were considered adequate for inclusion in further analyses.

Table 7

Internal Consistency (Cronbach's α) for Factors Derived from Item 7 of the PHSQ

Factor	*N*	Cronbach's α
Informal-Scenario 1	247	.63
Professional-Scenario 1	252	.77
School-Scenario 1	274	.76
Informal-Scenario 2	277	.65
Professional-Scenario 2	282	.74
School-Scenario 2	277	.65
Informal-Scenario 3	276	.67
Professional-Scenario 3	285	.74
School-Scenario 3	284	.66

Part 2: Problem Identification and Help-Seeking Intentions

Scenario 1: Nonclinical Problem (Mild)

For Scenario 1, 84% of parents correctly *identified* that the adolescent was experiencing a nonclinical problem. In addition to this, 8.2% of parents identified the problem as depression, 4.1% identified the problem as depression with other issues, 0.7% identified the problem as a clinical issue that did not include depression, and 3.1% identified the problem as a subclinical issue. A chi square goodness-of-fit test was conducted to determine if the observed frequency of parents rating the scenario as a nonclinical problem was significantly greater than would be expected based on chance. All categories being equal (i.e., expected frequencies of 20% per category) was the null hypothesis. Results revealed that the observed responses to Scenario 1 differed significantly from that which would be expected based on chance, χ^2 (4) =

757.26, $p < .001$. This suggests that parents identifying the problem type as being nonclinical was not due to chance alone.

For the level of *severity* of Scenario 1, 77.2% of parents rated the problem as 'mild', 22.4% rated the problem as 'moderate', and 0.3% rated the problem as 'severe'. A chi square goodness of fit test revealed that parents' ratings differed significantly from chance, χ^2 (2) = 284.93, $p < .001$. That is, significantly more parents rated the level of severity as mild than would be expected by chance alone.

When asked whether they believed the adolescent depicted in the scenario required help, 56.7% of parents indicated *yes*, and 43.3% indicated *no*. The sources that parents believed the adolescent depicted in Scenario 1 should turn to for help are presented in Figure 1. It can be seen from this chart that parents tended to recommend informal sources of help (e.g., parent, friend, other adult relative), followed by school based resources (e.g., school counsellor, teacher, school nurse), and few recommended religious or professional/formal types of help (e.g., psychologist, psychiatrist, doctor).

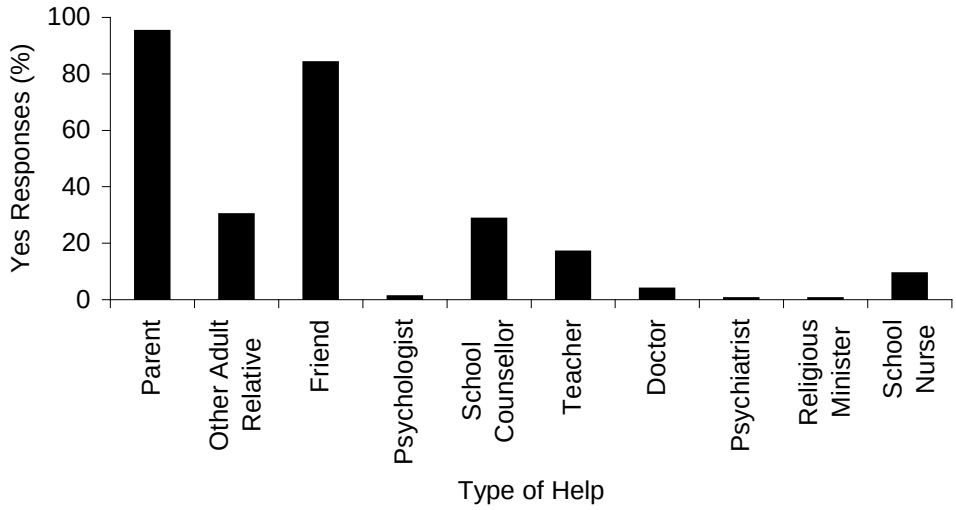

Figure 1. Percentage of parents rating each source of help as appropriate for Scenario 1.

When asked whether they would seek help for their own child if they were experiencing a problem similar to the adolescent depicted in Scenario 1, 55.2% of parents indicated *yes*, and 44.8% indicated *no*. The sources of help that parents indicated they would turn to if their own child was experiencing a similar problem are presented in Figure 2. It can be seen from this chart that parents again preferred informal sources of help, followed by school-based resources, and few would seek help from professional or religious sources of help. None of the parents indicated that they would seek help from a psychiatrist for a problem of this nature.

Comparing parents' belief that the adolescent depicted in the scenario required help with parents' intentions to seek help for their own child if they were experiencing a similar problem, a chi square test of independence revealed that parents were significantly more likely to suggest the child in the scenario needed to seek help than were willing to seek help for their own child in that situation, χ^2 (1) = 7.86, $p < .05$.

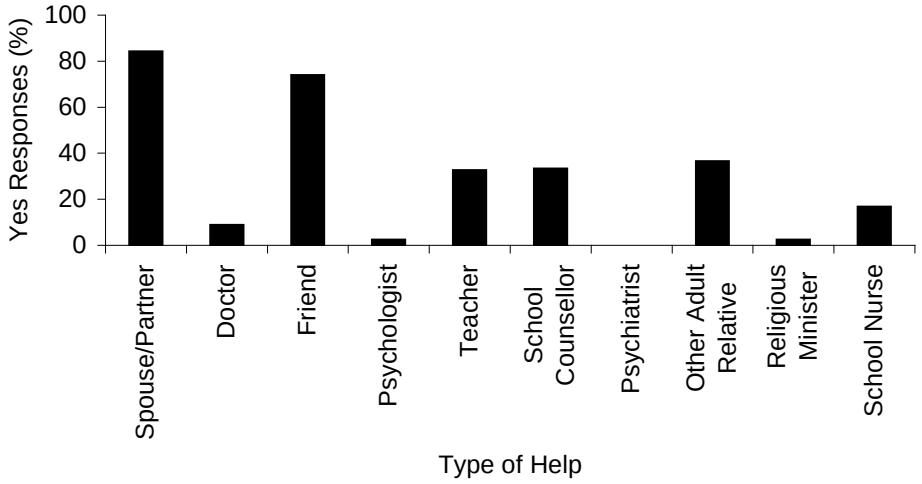

Figure 2. Percentage of parents indicating that they would seek help from each help source if their own child was experiencing problem depicted in Scenario 1.

Scenario 2: Dysthymic Disorder (Moderate)

For Scenario 2, 32.4% of parents correctly identified that the adolescent was experiencing a form of depression. Additionally, 28.2% of parents identified the problem as depression with other issues, 3.2% identified the problem as a clinical issue that did not include depression, 16.9% identified the problem as a subclinical issue, and 19.4% identified a nonclinical problem. A chi square goodness-of-fit test revealed that the type of problem identified by parents in Scenario 2 differed significantly from that which would be expected based on chance, χ^2 (4) = 72.94, $p <$ .001, the null hypothesis being that expected frequencies would be equal across categories. Significantly more parents identified the problem type as being either depression or depression and other clinical issues than would be dictated by chance alone.

For the level of severity of Scenario 2, 7.3% of parents rated the problem as 'mild', 59.7% rated the problem as 'moderate', and 33% rated the problem as 'severe'. A chi square goodness-of-fit test revealed that parents' ratings differed significantly from chance, χ^2 (2) = 123.26, $p <$ .001. That is, significantly more parents correctly rated the level of severity as moderate than would be expected by chance.

When asked whether they believed the adolescent depicted in the scenario required help, 96% of parents indicated *yes*, and 4% indicated *no*. The sources that parents believed the adolescent depicted in Scenario 2 should turn to for help are presented in Figure 3. It can be seen from this chart that parents were the preferred help-seeking option, followed by school counsellor, doctor, teacher, and friend. Less than half of parents indicated that the adolescent should seek help from other adult relatives, school nurse, psychologist, psychiatrist, or religious minister.

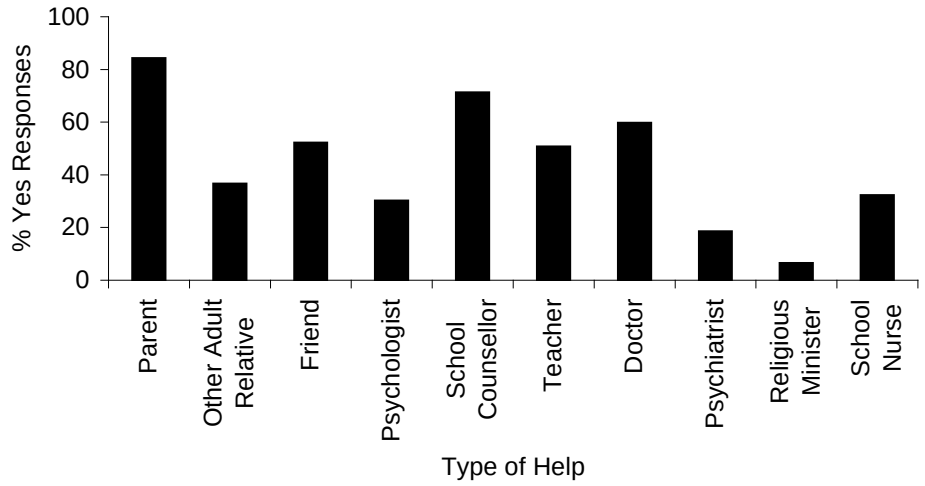

Figure 3. Percentage of parents rating each source of help as appropriate for Scenario 2.

When asked whether they would seek help for their own child if they were experiencing a problem similar to the adolescent depicted in Scenario 2, 93.6% of parents indicated *yes*, and 6.4% indicated *no*. The sources of help that parents indicated they would turn to if their own child was experiencing a similar problem are presented in Figure 4. It can be seen from this chart that spouse/partner was the preferred help-seeking option, followed by school counsellor, doctor, teacher, and friend. Less than half of parents indicated that they would seek help from other adult relatives, school nurse, psychologist, psychiatrist, or religious minister.

A chi square test of independence failed to find any significant difference between parents' belief that the adolescent depicted in the scenario required help and parents' intentions to seek help for their own child if they were experiencing a similar problem, χ^2 (1) = 1.77, $p > .05$.

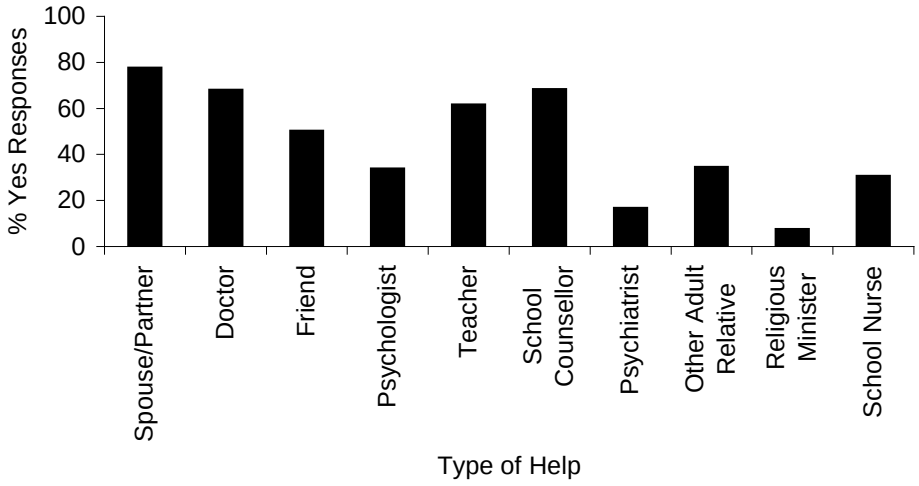

Figure 4. Percentage of parents indicating that they would seek help from each help source if their own child was experiencing problem depicted in Scenario 2.

Scenario 3: Major Depressive Disorder (Severe)

For Scenario 3, 21.9% of parents correctly identified that the adolescent was experiencing depression. Additionally, 35.3% of parents identified the problem as depression with other issues, 23.3% identified the problem as a clinical issue that did not include depression, 12% identified the problem as a subclinical issue, and 7.5% identified a nonclinical problem. A chi square goodness-of-fit test revealed that the type of problem identified by parents in Scenario 3 differed significantly from that which would be expected based on chance, with the null hypothesis being that expected frequencies would be equally distributed across categories. Significantly more parents identified the problem type as being depression and other clinical issues than would be dictated by chance alone, χ^2 (4) = 68.24, $p < .001$.

For the level of severity of Scenario 3, 4.3% of parents rated the problem as mild, 36.5% rated the problem as moderate, and 59.2% rated the problem as severe. A chi square goodness-of-fit test revealed that parents' ratings differed significantly

from chance, χ^2 (2) = 136.24, $p < .001$. That is, significantly more parents rated the level of severity as 'severe' than would be expected by chance alone.

When asked whether they believed the adolescent depicted in the scenario required help, 98% of parents indicated *yes*, and 2% indicated *no*. The sources that parents believed the adolescent depicted in Scenario 3 should turn to for help are presented in Figure 5. It can be seen from this chart that parents were the preferred help-seeking option, whilst school counsellor and doctor were also popular choices. Less than half of parents indicated that the adolescent should seek help from friend, teacher, psychologist, other adult relative, and school nurse, and less than one quarter would choose a psychiatrist or religious minister.

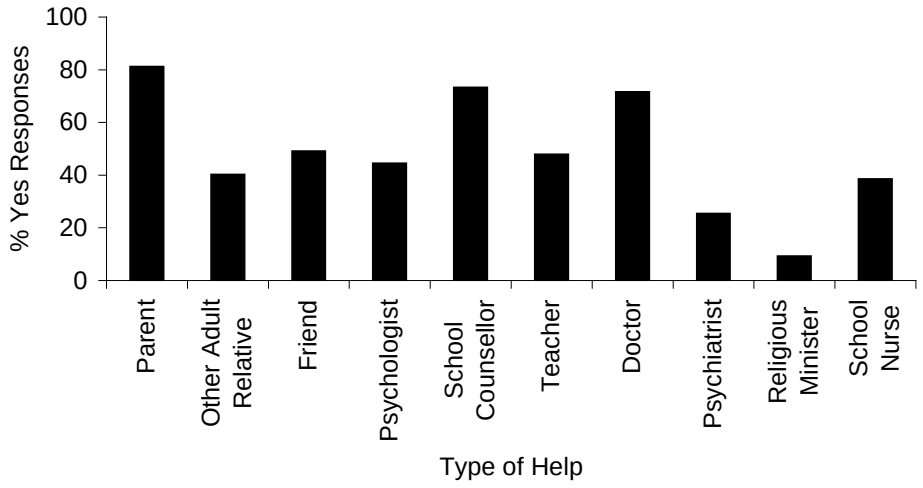

Figure 5. Percentage of parents rating each source of help as appropriate for Scenario 3.

When asked whether they would seek help for their own child if they were experiencing a problem similar to the adolescent depicted in Scenario 3, 97.3% of parents indicated *yes*, and 2.7% indicated *no*. The sources of help that parents indicated they would turn to if their own child was experiencing a similar problem are

presented in Figure 6. It can be seen from this chart spouse/partner and doctor were the preferred help-seeking options, followed by school counsellor and teacher. Less than half of parents indicated that they would seek help from a friend, psychologist, other adult relative, school nurse, psychiatrist, and lastly, religious minister.

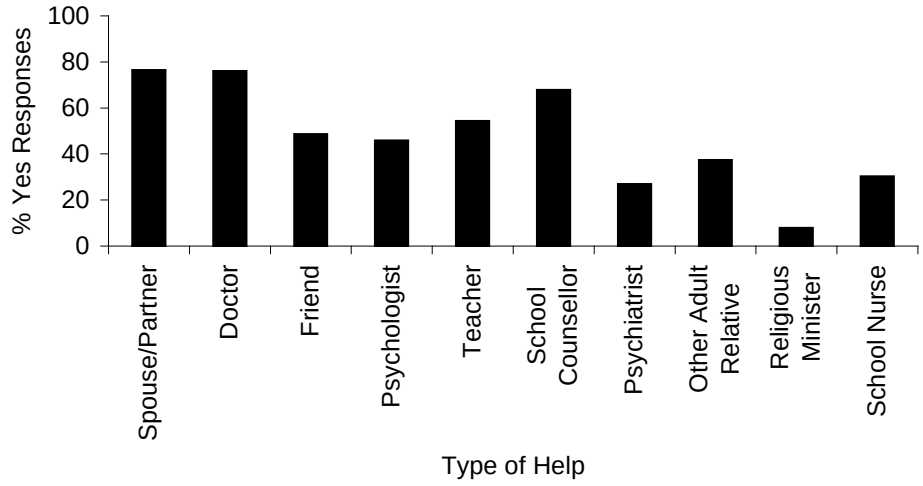

Figure 6. Percentage of parents indicating that they would seek help from each help source if their own child was experiencing problem depicted in Scenario 3.

A chi square test of independence failed to find any significant difference between parents' belief that the adolescent depicted in the scenario required help and parents' intentions to seek help for their own child if they were experiencing a similar problem, χ^2 (1) = .31, $p > .05$.

Part 3: Predictors of Help-Seeking Intentions

Preliminary Analysis and Assumption Testing

Descriptive statistics for the nine dependent variables are presented in Table 8. Analysis of skewness and kurtosis values combined with visual inspection of histograms revealed that these variables were normally distributed with the exception

of Professional-Scenario 1 and School-Scenario 1. This was confirmed by an examination of Q-Q plots. To address variables violating the normality assumption, inspection of box plots revealed statistical outliers for Professional-Scenario 1 and School-Scenario 1 variables. These outliers were subsequently deleted. ARIA scores and SEIFA scores remained unevenly distributed but could not be transformed to a normal distribution.

Table 8

Means, Standard Deviations, Skew, and Kurtosis for Dependent Variables

	N	*M*	*SD*	Skew	Kurtosis
Informal-Scenario 1	247	10.06	3.05	-.25	-.46
Professional-Scenario 1	246	3.65	1.25	2.13	4.32
School-Scenario 1	271	6.64	3.23	1.30	1.01
Informal-Scenario 2	277	10.91	3.02	-.34	-.64
Professional-Scenario 2	282	8.47	3.46	.19	-.96
School-Scenario 2	277	11.23	3.77	-.24	-.63
Informal-Scenario 3	276	11.16	2.30	-.43	-.64
Professional-Scenario 3	285	9.76	3.58	-.16	-1.05
School-Scenario 3	284	11.53	3.81	-.17	-.67

The statistical assumptions underlying multiple regression were also examined. Examination of residual plots revealed the assumptions of linearity and homoscedasticity were met. There was also no evidence of multicollinearity or singularity between the predictor variables. With regards to sample size, a ratio of 40 cases to every independent variable is recommended when employing the stepwise method (Pallant, 2005; Tabachnick & Fidell, 2001). Furthermore, multiple regression

is extremely sensitive to the combination of variables included within an analysis, in that the significance of a particular independent variable can be influenced by the other independent variables included within that set (Tabachnick & Fidell, 2007). In order to address both of these issues, predictor variables were selected to ensure an adequate case to independent variable ratio, whilst also ensuring the smallest optimal set of independent variables were included (Tabachnick & Fidell, 2007). Thus, four independent variables (ARIA scores, SEIFA scores, marital status, and previous psychological/mental health problem experienced by parent) were included in the regression analysis. ARIA scores were included due to the study's focus on rurality, whilst the remaining variables were chosen based on past research indicating that these factors may have an important influence on parental help-seeking (e.g., Eapen & Ghubash, 2004; Raviv et al., 1992; Zwaanswijk et al., 2003). The predictive power of these four independent variables were examined for each help source (i.e., professional, school-based, and informal sources of help).

Regression Analyses

Prior to the regression analyses, correlation coefficients (Spearman's rho) for the dependent variables with ARIA (rurality) scores and SEIFA scores (socio-economic status) are presented in Table 9. This table shows that there was little correlation between the likelihood of seeking help from different help-seeking sources and rurality and socio-economic advantage/disadvantage.

Table 9

Correlations between Dependent Variables and ARIA scores and SEIFA scores

	ARIA	SEIFA
Professional-Scenario 1	-.07	-.11
Professional-Scenario 2	.07	.13*
Professional-Scenario 3	-.00	.02
School-Scenario 1	.06	-.08
School-Scenario 2	.16**	-.09
School-Scenario 3	.10	-.12*
Informal-Scenario 1	-.07	-.05
Informal-Scenario 2	-.00	-.13*
Informal-Scenario 3	.01	-.10

Note. * $p < .05$. ** $p < .01$.

A series of regression analyses using a stepwise method of entry was conducted to determine which independent variables were able to best predict the likelihood of seeking help, a continuous variable, from various help sources for each of the three scenarios (Field, 2005; Francis, 2001). The predictors examined were ARIA scores, SEIFA scores, marital status, and previous psychological/mental health problem experienced by parent. Marital status was collapsed into married/not married to form a dummy variable.

Professional Help Sources. Results of the first regression analysis for the likelihood of seeking help from professional sources for each scenario are presented in Table 10. Results indicated that 2% of variance in likelihood of seeking help from professional sources for Scenario 1 was explained by previous mental health problem experienced by parent, adjusted R^2 = .02; $F(1, 243) = 6.39$, $p = .01$. Previous mental health problem experienced by parent and SEIFA scores accounted for 3% of variance in likelihood of seeking help from professional sources for Scenario 2, adjusted R^2 = .03; $F(2, 279) = 5.46$, $p = .01$, whilst previous mental health problem experienced by parent explained 2% of variance in likelihood of seeking help from professional sources for Scenario 3, adjusted R^2 = .02; $F(1, 282) = 7.35$, $p = .01$.

Table 10 shows standardised and unstandardised coefficients with their standard error and level of significance for each regression equation. It can be seen from this table that previous mental health problem experienced by parent was a significant predictor for seeking help from professional help sources across all three scenarios.

Table 10

Regression Analyses of Professional Help Sources with ARIA, SEIFA, Marital Status, and Previous Mental Health Problem experienced by Parent as Predictors

	B	*SE B*	β	*T*
Professional-Scenario 1 (Mild)				
Parent previous mental health problem	.65	.26	.16	2.53*
Professional-Scenario 2 (Moderate)				
SEIFA	.03	.01	.14	2.36*
Parent previous mental health problem	1.63	.69	.14	2.36*
Professional-Scenario 3 (Severe)				
Parent previous mental health problem	1.91	.71	.16	2.71**

Note. * $p < .05$. ** $p < .01$.

School-Based Help Sources. Results of the regression analysis for the likelihood of seeking help from school-based sources are presented in Table 11. Results indicated that 1% of variance in likelihood of seeking help from school-based sources for Scenario 2 was explained by marital status (i.e., married or not married), adjusted $R^2 = .01$; $F(1, 274) = 4.23$, $p = .04$. No significant predictors of likelihood of seeking help from school-based sources were found for Scenario 1 or 3.

Table 11

Regression Analyses of School-Based Help Sources with ARIA, SEIFA, Marital Status, and Previous Mental Health Problem experienced by Parent as Predictors

	B	*SE B*	β	*T*
School-Scenario 2 (Moderate)				
Marital status	1.31	.64	.12	2.01*

Note. * $p < .05$.

Informal Help Sources. Results of the regression analysis for the likelihood of seeking help from informal sources are presented in Table 12. Results indicated that 1% of variance in likelihood of seeking help from informal sources for Scenario 2 was explained by previous mental health problem experienced by parent, adjusted R^2 = .01; $F(1, 274) = 4.67$, $p = .03$. No significant predictors of likelihood of seeking help from informal sources were found for Scenarios 1 or 3.

Table 12

Regression Analyses of Informal Help Sources with ARIA, SEIFA, Marital Status, and Previous Mental Health Problem experienced by Parent as Predictors

	B	*SE B*	β	*T*
Informal-Scenario 2 (Moderate)				
Parent previous mental health problem	-1.32	.61	-.13	-2.16*

Note. * $p < .05$.

Logistic Regression

A forward stepwise logistic regression analysis was performed to examine predictors of parents' help-seeking intentions for their own child. Specifically, the model predicted affirmative responses to the question, "if your own son/daughter was experiencing a problem similar to (adolescent depicted in scenario), would you ask for help on his/her behalf?" for each of the three scenarios. The predictors examined were ARIA scores, SEIFA scores, marital status, and previous psychological/mental health problem experienced by parent. Results of the logistic regression analysis, however, failed to reveal any significant predictors of parent's intentions to seek help for their own child.

Discussion

Summary of Findings

Study 1 examined the help-seeking responses of parents of rural adolescents when presented with hypothetical scenarios depicting an adolescent with depression. The aims of this study were to determine whether parents of rural adolescents were able to identify the nature and severity of depressive symptoms among adolescents in accordance with the initial stage of the help-seeking process. Also, this study aimed to extend knowledge beyond the initial stage of problem recognition by investigating the help-seeking intentions of parents of rural adolescents once a problem has been identified, by exploring their preferred sources of help as well as the factors that predict parents' help-seeking intentions in the rural context.

Results from Study 1 supported the hypotheses that when presented with a series of hypothetical scenarios in which descriptions of adolescents with depression are depicted, rural parents will be able to (a) correctly identify depression, and (b) correctly identify the level of severity at rates higher than those expected due to

chance alone. Regarding identification of the problem type, parents demonstrated an ability to recognise symptoms of depression – more than half identifying the problem as either depression or depression and other issues (e.g., drug use, eating disorder, low self-esteem, bullying). Results also indicated that rural parents were able to distinguish between the level of severity (mild, moderate, severe) of each problem depicted. With regards to identification of a need for help, rural parents reported a need for help that increased with the severity of the problem depicted. That is, as the severity of the problem increased from mild through to severe, so to did the number of parents reporting that the adolescent needed help to manage their problem.

The hypothesis that parents would be more likely to refer the adolescent depicted in the scenario for help than they would be to seek help if their own child was experiencing a similar problem was not supported. For the nonclinical problem (Scenario 1), parents were significantly more likely to indicate that the child in the scenario should seek help than they were to indicate that they would seek help for their own child. However, no differences were found between parents' beliefs that the adolescent in the scenario required help and parents' intentions to seek help for their own child if they were experiencing a similar problem for the clinical/depression scenarios (Scenario 2 and 3). That is, parents were equally likely to refer someone else's adolescent and their own to seek help for depression.

Considering different sources of help, rural parents were consistent in the types of help they recommended for the adolescents depicted in scenarios and those preferred for their own child. For the mild/nonclinical problem parents tended to favour informal sources of help such as parent or spouse/partner, friend, or adult relative. For the moderate problem (i.e., dysthymic disorder) parent or spouse/partner was the preferred help-seeking option, followed by school counsellor, doctor, teacher, and friend. For the severe problem (i.e., major depressive episode) parent or

spouse/partner and doctor were the preferred help-seeking options, followed by school counsellor and teacher. Less than half of rural parents indicated that they would seek help from other adult relatives, school nurse, psychologist, psychiatrist, or religious minister for an adolescent with depression.

Finally regarding predictors of rural parents' help-seeking intentions, results indicated that previous mental health/psychological problems experienced by parents was the best predictor of parents' intentions to seek help from professional help sources (i.e., psychologist, psychiatrist, doctor). That is, rural parents who had a past history of a mental health problem themselves were more likely to refer the adolescent to professional help sources. No other factors were found to consistently predict parents' help-seeking intentions across all scenarios.

Interpretation of Findings

Addressing the initial stage of the help-seeking process, findings from Study 1 demonstrated that parents of rural adolescents who had not had prior experience with a child experiencing a mental health problem were able to recognise the symptoms of depression, albeit to a limited extent. Whilst a majority of rural parents identified depression as a possible explanation for the problems depicted, approximately half of these parents listed depression among a number of other potential problem types (e.g., eating disorder, substance abuse, health-related issues).

Considering these findings in the context of past literature, limited research in this area to date has found that parents lack an awareness of adolescent problems and are poor at recognising symptoms of depression. For example, Hartos and Power (1997) found that mothers lack awareness of their adolescents' problems, with adolescents reporting experiencing more stressors than their mothers identified. Similarly, Teagle (2002) found that less than 40% of parents of a child with a

psychiatric diagnosis identified that they were experiencing a problem, particularly for adolescents, whilst Logan and King (2002) found that parents of adolescents meeting the diagnostic criteria for a depressive disorder were poor at recognising symptoms of depression in their child. Findings of the present study contradict past research to some degree. Unlike the findings of Hartos and Power and of Teagle, parents in the present study were clearly aware that the adolescent depicted in the scenario was experiencing a problem, in most cases recognising that depression was a component of the problem, and also recognising that it was a problem that required help. However, it should be noted that the methodology of the present study differed to that of previous studies, in that parents in this study rated hypothetical scenarios whereas the aforementioned studies involved parents rating their own child's symptomatology.

In addition to being able to identify a problem that required help, parents of rural adolescents were also able to identify the severity of the problem, with the majority accurately rating the problems depicted as mild, moderate, or severe. This finding is unique in that it suggests that regardless of whether parents are able to specifically identify that their child is experiencing depression, they are able to recognise that their child is experiencing a problem of a certain degree of severity. Whilst such a result has not been reported in past research, it may partly account for the finding by Logan and King (2002) that parents of depressed adolescents who failed to identify symptoms sufficient to meet the diagnostic criteria of depression using the DISC endorsed sufficient items to make a rating of moderate to severe mood/emotional impairment on a dimensional scale (CAFAS Moods/Emotions subscale). Thus, it may not be recognition of the specific problem type but rather the perceived level of severity that parents identify as cause for concern, which in turn determines their intentions to seek help and initiates the help-seeking process.

With regards to parents' intentions to seek professional help, the finding that the intention of parents of rural adolescents to seek help increased with the severity of the problem is encouraging. Whereas much evidence exists in past literature showing that problems of greater severity tend to create more burden on parents (Angold et al., 1998; Sayal, 2004, 2006; Sears, 2004; Zwaanswijk et al., 2003), the ability of parents of rural adolescents to identify an appropriate need for care is of particular importance given the challenges rural adolescents face in accessing help. It is becoming increasingly recognised that rural residents, and rural adolescents in particular, face a distinct disadvantage in accessing appropriate mental health care (Boyd et al., 2006). Challenges faced by rural adolescents include a lack of available and appropriate services, stigmatising community attitudes towards mental illness leading to social exclusion, a lack of anonymity, and a culture of self reliance which views seeking help for a mental health problem as a sign of weakness (Aisbett et al., 2007; Boyd et al., 2007; Francis et al., 2006). These challenges, which may be considered as specific to the rural context, make it especially difficult for these adolescents to seek help on their own. The finding that parents who reside in rural areas are able not only to identify the severity of an adolescent's problem, but that they also recognise a need to intervene and are willing to seek help accordingly, suggests promising implications for the role of parents in mediating pathways to care for rural adolescents with depression.

A somewhat unexpected result with regards to help-seeking intentions was the finding that there was no difference between parents' belief that the adolescent in the scenario should seek help, and intentions to seek help for their own child for depression. Past research by Raviv, Raviv, Edelstein-Dolev, et al. (2003) found that mothers were more willing to refer someone else's child for psychological help than their own, interpreting this finding to reflect the threat to self-esteem incurred by a

parent when referring one's own child. Whilst one might have expected that parents of rural adolescents would also have been reluctant to seek help for their own child due to similar threats to self esteem that may be incurred through fear of social stigma existing in a rural community, the finding that they were equally willing to seek help for their own child for depression is also encouraging.

It is possible that this finding may be explained in terms of the strong social ties that exist in rural communities. The concepts of *social capital* (McKenzie & Harpham, 2006; Putnam, 2002) and *sense of community* (Pretty, Chipuer, & Bramston, 2003) describe how social networks that exist in communities create value both individually and collectively, through characteristics of community networks such as community engagement and participation, a sense of belonging and solidarity between community members, norms of reciprocity, co-operation and an obligation to help others, and trust in the community (McKenzie & Harpham, 2006; Putnam, 2002). Furthermore, social capital is purported to be particularly relevant to rural communities where relationships within the community are embedded in networks of close personal ties and a strong sense of community (Boyd, Hayes, Wilson, & Bearsley-Smith, 2008; Hofferth & Iceland, 1998; Pretty et al., 2003). These strong social networks may explain why no difference between parents' belief that the adolescent in the scenario should seek help, and intentions to seek help for their own child for depression was found in the present study. For parents living in rural areas, close community ties and norms of reciprocity may mean that parents regard the needs of their own and another child equally, and as such have the same view towards each in terms of seeking help.

Considering the sources of help that parents preferred, parents were consistent in the types of help they recommended for the adolescents depicted in scenarios. Across all three scenarios spouse/partner (or in the case of the adolescent in the

scenarios, the corresponding option of 'parent') was identified as the preferred help-seeking option. This is consistent with past research on parental help-seeking (e.g., Raviv et al., 1992), and a preference for informal help reported in the adolescent help-seeking literature (Boldero & Fallon, 1995; Offer et al., 1991).

Aside from informal sources of support, doctors, school counsellors, and teachers were the favoured help-seeking options for adolescents with depression, with less than half of parents indicating that they would seek help from a mental health professional (i.e., psychologist or psychiatrist). The finding that parents did not view mental health professionals as a favoured help-seeking option is somewhat concerning given the large proportion of adolescents who fail to receive professional help from mental health services (Sawyer et al., 2007). Whilst reasons for parents' preferred help-seeking choices were not examined in this study, it is possible that factors associated with rural residency may have impacted upon parents' help-seeking preferences. For example, parents may have identified that such services were not available or easily accessible in their area and as such, did not select them. Alternatively, rural parents may feel a perceived stigma associated with seeking help from a mental health professional, which past research indicates is more prolific in rural communities (Boyd et al., 2007; Francis et al., 2006; Fuller et al., 2000), and as such avoided these sources of help.

In an attempt to clarify the reasons behind parents' preferred help-seeking choices, predictors of parents' help-seeking intentions from various sources of help were examined. The only significant finding across all scenarios with regards to predictors of help-seeking intentions was that parents who had a past history of a mental health problem themselves were more likely to recommend professional help sources (i.e., psychologist, psychiatrist, doctor). One possible interpretation of this finding is that those parents who have had personal experience with a mental health

problem may have better knowledge and awareness of how and where to seek professional help. Alternatively, parents who have had a mental health problem themselves may be more accepting of seeking help from professional sources due to their own experiences in seeking treatment.

Past research regarding parental psychopathology and adolescent service use has, however, been mixed. Whilst some have reported a positive association between parental psychopathology or past psychological treatment of parents and help-seeking for their child (Zwaanswijk et al., 2003), others have found either no association (e.g., Logan & King, 2002), or a negative relationship in that parental psychopathology served as a barrier to mental health service use (e.g., Cornelius, Pringle, Jernigan, Kirisci, & Clark, 2001; Flisher et al., 1997). A possible explanation for these varied findings might be whether the parents examined were experiencing an active phase of mental illness, or whether they had a mental health problem in the past from which they had recovered or which was being effectively managed/treated. If a parent is experiencing an active phase of mental illness, they may be struggling to manage their own difficulties and may not have the personal resources to cope with their adolescent's problem as well. In the case of the present study, it is unknown as to whether parents were experiencing an active phase of mental illness, as this was not assessed. However, it could be speculated that such parents may have been less likely to complete a questionnaire (due to demands of their mental health condition) and therefore would not have been included as participants.

Methodological Limitations

There are, however, several methodological issues that must be taken into consideration when interpreting the results of this study. These include sampling

issues, possible lack of representativeness, and measurement issues involved in the use of a newly developed questionnaire.

With regards to sampling issues, the response rate of 21% limits the generalisability of the results. Furthermore, there was a lack of variation in ARIA scores of the participating schools and subsequently a lack of variation in rurality of the resultant sample. Of the schools agreeing to participate, 12 were from areas classified as Outer Regional, 2 were classified as Inner Regional, and 1 was classified as Remote. Of those parents who responded, 88.49% were from Outer Regional Australia, 7.89% from Inner Regional Australia, and only 3.62% from Remote Australia, resulting in a sample that was quite disproportionate in terms of remoteness from services (ARIA scores). This lack of variation in ARIA scores may explain why level of rurality (ARIA scores) was not found to predict help-seeking intentions in Study 1, as there was simply not sufficient variability in the data to detect any differences. Also, it has been suggested that rural Australia is diverse and changing, with individual rural communities having many unique characteristics (Fraser et al., 2002). A lack of variation in the present sample, therefore, may mean that some rural areas were poorly represented and that findings may not generalise to other more remote areas of the country. Additionally, no urban comparison group was used in this study, as comparisons between parent help-seeking in rural as opposed to metropolitan areas was not an aim of the present study. Such rural-urban comparisons may be useful to consider in future research.

A measurement issue that may have limited findings of Study 1 was the development and use of the PHSQ. Given that no previous measures were available to assess parental help-seeking intentions, the PHSQ was developed to address this gap. As with the use of any new measure, issues of reliability and validity are inherent limitations that need to be considered. In an attempt to address some of these

measurement issues, clinician ratings of scenarios were obtained to ensure content validity. Also, analyses performed to assess internal consistency and inter-rater reliability for scoring of the scenarios were found to be adequate. Further use and testing of the PHSQ would need to be undertaken to address other issues of reliability and validity.

A further limitation for the use of the PHSQ is that it only assesses parents' responses to hypothetical scenarios. Whilst parents demonstrated an ability to recognise the severity of the problem, and to a lesser extent the problem type, it cannot be said for certain that this would be the case if presented with such a problem in a "real life" context. Similarly, the PHSQ only assessed *intentions* of parents to seek help, making it unclear as to whether these intentions would necessarily translate into actual help-seeking behaviour. Given the many challenges rural residents face in seeking help, it is highly possible that whilst rural parents have intentions to seek help for their child, the barriers they encounter may actually prevent or impede this. Alternatively, parents' knowledge of the study aims may have influenced the way they responded regarding their help-seeking intentions. The plain language statement provided to all parents contained information about the purpose of the study, including that it aimed to examine ways parents can help adolescents. Parents were therefore not naïve to the purposes of the study and this may have influenced the study findings. That is, parents may have reported that they would seek help for their child because they knew that this is what the study was examining, rather than this being a true reflection of their help-seeking intentions.

In summary, findings from Study 1 suggest that parents are in the position to play a key role in facilitating pathways to care for rural adolescents. The finding that parents were able to recognise the severity of adolescents' problems and that their intentions to seek help increased accordingly offers promising new information about

the role that parents can play in the help-seeking process. This finding is particularly encouraging for rural adolescents with depression, given the added challenges they face in seeking help. Furthermore, these findings raise a number of important theoretical and clinical implications which will be discussed in greater detail in Chapter 4.

Chapter 3: Study 2

In Study 2, qualitative accounts of the help-seeking process from parents of rural adolescents with depression who have sought professional help for their adolescents are analysed. The aim of this study was to explore the experiences of parents who have sought help for an adolescent with depression beyond initial problem recognition to provide a more comprehensive understanding of how this parent-mediated process unfolds in a regional setting.

Method

Participants

A sample of 7 parents who had each assisted their adolescent child to seek professional help for depression participated in this study. Initially, attempts were made to recruit participants through Child and Adolescent Mental Health Services (CAMHS). The inclusion/exclusion criteria at this point were as follows: adolescents must be aged between 13 to 18 years, have received a primary diagnosis of unipolar depression (Major Depression, Dysthymia), be living at home with at least one parent, and have sought help from CAMHS within the last 12 months. Children who were under 13 years of age, experiencing an active phase of mental illness, current substance abuse/dependence or suicidal intent, or whose parent had a mental illness were to be excluded.

After a 9 month period, attempts to recruit through CAMHS failed to provide any willing participants. This recruitment strategy was then abandoned, and participants were recruited via advertisements placed in a local newspaper (see Appendix M). At this stage, the initial inclusion/exclusion criteria developed for

CAMHS were reviewed and altered to reflect the broader population from which the sample would be obtained. To be included, parents must have had prior experience in identifying and assisting their adolescent child to seek professional help for depression within the past 5 years, the adolescent must have experienced unipolar depression (as opposed to bipolar), and the adolescent must not have been demonstrating current suicidal intent or have committed suicide.

A total of 18 people responded to the advertisement, of which 10 were invited to interview. Of the 8 respondents who were not invited to participate, 1 was unable to be contacted within the study timeframe, and 7 did not meet study inclusion criteria. Of the 7 excluded, 4 had sought help for their child over 5 years ago, 2 of the respondent's children did not have a diagnosis of unipolar depression, and 1 respondent's child had committed suicide.

Of the 10 people invited to participate, 1 participant did not attend their interview and two interviews were excluded as they did not meet the study criteria. The person who did not attend their interview was not rescheduled due to time constraints of the project and because an adequate sample size (Morse, 2000) had been obtained. Of the interviews excluded, for the first it was determined that the onset of depression and commencement of the help-seeking process had occurred during childhood (not adolescence), whilst the second was excluded as the child's help-seeking pathway had been mediated by the school rather than by the parents. This resulted in a total sample of 7. All of the participants were married and 6 of the participants were employed at the time of interview. Five participants had tertiary qualifications and a professional employment background.

Materials

A set of semi-structured interview questions were developed, specifically addressing the aims of this study (see Appendix N). These questions served as a guide for in-depth interviews that were conducted with each participant.

Methodological Framework

As this study aimed to explore the unique experiences of parents who have assisted an adolescent with depression through the help-seeking process, an interpretive phenomenological methodological framework was applied. The phenomenological approach to qualitative research in psychology aims to provide a detailed account of the participant's own perspective regarding the topic of interest (Smith, Jarman, & Osborn, 1999; Willig, 2001). It is concerned with representing an individual's personal account or experience of a particular event (Smith & Osborn, 2003; Willig, 2001). In the present study, this methodological approach was utilised to enable a better understanding of the help-seeking process through the first-hand accounts and viewpoints of parents who had lived through that experience.

Whilst the phenomenological approach endeavours to access and describe the participant's own personal experience, it recognises that the process involves a dynamic interplay between the participant and researcher, and the researcher's own views and conceptions (Willig, 2001). Smith and Osborn (2003) describe a two-stage interpretation process, or double hermeneutic, whereby "…the researcher is trying to make sense of the participants trying to make sense of their world" (p. 51). Thus, implicit to the phenomenological analysis process is both a description and *interpretation* of the experience put forward by the participant (Smith et al., 1999).

Data analysis. In the present study, the interview transcripts were analysed following a recommended four stage approach to Interpretive Phenomenological Analysis (IPA; Smith et al., 1999; Smith & Osborn, 2003). To begin, the first transcript was read thoroughly three times and initial impressions of the data were noted. These initial notes were then reviewed and re-examined to identify emerging themes, which were then labelled. In the third step, connecting themes were organised into clusters and labelled to reflect their shared meaning or hierarchical relationships between themes. Finally, the initial thematic structure developed from the first case was used to analyse the remaining transcripts. Rigorous rechecking between transcripts was conducted to ensure newly emerging themes were in fact original, and not merely a new manifestation of an earlier recorded theme. As new themes emerged across transcripts, the superordinate thematic structure was refined accordingly.

The role of the researcher in qualitative analysis. Given the inherently subjective nature of the IPA approach, it is important to consider the role of the researcher and how their views and experiences may impact upon the research process. From the phase of interview through to data interpretation, the researcher brings his or her own agenda, background, and preconceptions. These in turn have the potential to influence the course and direction of an interview, as well as the types of interpretations derived from the interview data.

In the present study, the student researcher was a provisional psychologist undertaking the project in partial fulfilment of a Professional Doctorate in Psychology (Clinical). The student researcher has been trained in the assessment, diagnosis, and treatment of psychological disorders in children, adolescents, and adults in accordance with the biopsychosocial model and a predominantly cognitive behavioural approach. The approach to interpretation and analysis of the data were heavily influenced by the

student researcher's alliance to the positivist research tradition which is prevalent in mainstream psychology.

Reliability and validity of qualitative research. The quality of qualitative research can be evaluated against key criteria that parallel the criteria used to judge quantitative research. These criteria include: *credibility*, which parallels internal validity and refers to the correspondence between participant perceptions and the researchers portrayal of these perceptions; *dependability*, which parallels reliability and reflects the appropriateness of the inquiry process; and *confirmability*, which parallels objectivity and endeavours to minimise the influence of the researcher's interpretations (Guba & Lincoln,1989).

Rigour can be introduced into qualitative research by using strategies that include: *persistent observation*, a strategy which requires the researcher to engage with the interview data long enough to identify the most salient themes; *prolonged and substantial engagement*, whereby the researcher engages with interview data until they are confident the themes are repeating and not extending; *peer debriefing*, whereby the researcher discusses their rationale for the data interpretation with a disinterested peer; *dependability audit*, whereby the researcher tracks changes throughout the research process; and a *confirmability audit*, which involves tracking interpretations back to the original source via an external auditing process (Guba & Lincoln,1989). Each of these strategies were employed to ensure the credibility, dependability, and confirmability of results in the present study.

Procedure

Ethical approval was sought from the University of Ballarat's Human Research Ethics Committee (see Appendices O and P) and Ballarat Health Service's Human Research Ethics Committee. Following ethical approval, meetings were

arranged with the CAMHS manager and staff to discuss the study aims and requirements. CAMHS were provided with copies of the plain language statement (see Appendix Q) and consent form (see Appendix R) for clinicians to distribute to the parents of clients meeting the study criteria.

After approximately 9 months of attempting to recruit participants via CAMHS without success, this avenue of recruitment was abandoned and an advertisement (see Appendix M) was placed in a local newspaper. People interested in participating were asked to contact the principal researcher, who then provided these persons' contact details to the student researcher for follow-up. The student researcher telephoned all people who had expressed an interest in the study, reviewing the nature and purpose of the study with them, and assessing the individual's suitability for the study. Those parents whose experiences met the study criteria were then asked if they would like to continue with the study, and if so, interview appointment times were arranged. A copy of the plain language statement and university map were mailed or emailed to parents who had agreed to participate.

Interviews were conducted at the University of Ballarat on an individual basis. Prior to commencing each interview, the student researcher reviewed the plain language statement with the parent and asked them to sign a consent form if they wished to continue with the study. Interviews were conducted in a semi-structured format whereby participants were asked to discuss their experiences as a parent seeking help for an adolescent child with depression. Interviews ranged from 55 minutes to 90 minutes in duration and all interviewing was conducted by the student researcher.

All interviews were digitally recorded. Data files were then transferred to the student researcher's laptop computer and password protected. Digital files were then transcribed verbatim and de-identified according to qualitative data transcription

guidelines outlined by McLellan, MacQueen, and Neidig (2003). Data were analysed by the student researcher in accordance with the principles of IPA (Smith et al., 1999; Smith & Osborn, 2003) and subsequently subjected to external audit by a retired Professor of Psychology with experience in qualitative research and confirmability audits (see Appendix S for a summary of comments and response to comments).

Results

Interview data were divided into two master themes reflecting (1) barriers and (2) facilitators encountered by parents in assisting rural adolescents with depression to negotiate the help-seeking process. Each master theme is then divided into specific sub-themes describing the types of barriers and facilitating factors identified by interviewees. Thematic descriptions are accompanied by key participant quotes illustrating each concept. Following the discussion of each master theme, matrix displays depicting the extent of data saturation are provided in Tables 13 and 14.

Master Theme 1: Barriers and Burdens for Parents in the Help-Seeking Process

Overall, the pathways to care described by parents were varied and idiosyncratic. For some parents and their children, appropriate professional help was found straight away, whilst others had to try several different service providers to get the help they required. Also, the type of professional help (e.g., GP, psychologist, psychiatrist, school counsellor) that was determined to be useful varied with each parent and adolescent's unique and individualised experiences. Whilst the overall process and pathways through care described by parents were quite varied, shared experiences emerged in the form of common barriers and facilitating factors that impacted upon this process.

Parents reported a number of negative experiences associated with their help-seeking journeys. From initial problem recognition to accessing professional help, parents encountered common problems and difficulties which were burdensome and acted as barriers in the help-seeking process. These barriers and burdens created additional pressure for parents and contributed to delays in adolescents receiving appropriate mental health care. The types of burdens and barriers encountered by parents were divided into sub-themes reflecting those factors which led to a delay in initial problem recognition, and those which negatively impacted upon parents' and adolescents' pathways through care.

Theme 1: Delays in Problem Recognition

Delays in problem recognition stemmed from parents experiencing difficulty differentiating between the developmental characteristics of adolescence and depression, and also through attributing their child's symptoms to a physical illness rather than a psychological illness.

Difficulty differentiating between developmental stage and depression. Parents reported experiencing difficulty in differentiating between developmental characteristics of adolescence and symptoms of depression. The common perception of adolescence being a tumultuous period created some ambiguity and confusion for parents, who tended to attribute their child's symptoms, at least initially, to 'normal' teenage behaviour. In many cases this led to a delay in problem recognition, and consequently, larger intervals between symptom onset and access to appropriate professional help. For example:

> I think it was hard to know because she was my eldest child and I probably put a lot of it down to adolescence. Like that kids are a bit withdrawn and perhaps don't tell their parents as much and they're moody and you know hormones and all that stuff. So I think perhaps it took, well not just me but my husband and me, time to see that it was really a bit more serious than that.

Symptoms of depression attributed to physical illness. Another difficulty for parents was recognising that the physical symptoms with which their child was presenting were due to depression, as opposed to a physical illness. Parents first tended to become aware of their child's physical symptoms before psychological symptoms, and on attributing these to a physical illness sought help appropriate to this (e.g., naturopath, doctor). It often took some time for parents to discover that an emotional or psychological component was underlying their child's difficulties, which again led to a delay in seeking appropriate professional help. For instance:

> When I look back it had been going for years and years I think. She's always presented with a lot of physical symptoms, of tummy aches and oh you know, "I feel sick", and headaches.

> …I thought he had a food allergy or something. He'd quite often feel sick in the morning and couldn't eat breakfast and so I was, thought oh well you know I'll see if that passes.

> …there'll be a sore knee, sore tummy, head, pimples…and that had gone on for 12 months and we use to think, "oh, for goodness sake", you know, I didn't pay much attention to any of it…

Theme 2: Burdens in Negotiating Pathways Through Care

In the process of seeking and accessing professional help for their child, parents faced common barriers and shared experiences of burden. The availability and accessibility of adolescent mental health services was seen as a barrier due to the rural

location in which families lived, whilst the financial pressure associated with accessing treatment was identified as a potential barrier in seeking help. Also, mothers reported feeling burdened by having to carry the primary responsibility for negotiating their adolescent's pathway to care. Community attitudes and perceived stigma towards mental illness was also identified as a common phenomenon that negatively impacted upon parents' perceptions of the help-seeking process.

Accessibility and availability of services. Some parents were frustrated by the lack of services available for adolescents in their town. In particular, parents were disappointed by the lack of facilities specialising in adolescent mental health and the lack of professionals with expertise in treating adolescent depression. They saw such service providers as being virtually non-existent, and reported having to travel out of town on a number of occasions to access specialised adolescent mental health professionals. The travel required to access professionals added to the burden felt by parents and to their overall difficulty in finding appropriate help for their child. To illustrate:

> I do think it's a shame that there's nowhere in =Regional Town= that umm, yes there's a psychiatrist, not that they're thick on the ground for a start, but there's sort of nowhere really for teenagers particularly to go and not a lot of support for them.

> …Even the fact that =Regional Town= doesn't have an adolescent unit. Um, I know they can go in here but it's with adults. There wasn't a psychiatrist here to manage it anyway. I was told by health professionals that most of our psychiatrists in =Regional Town= won't see adolescents, they won't treat them til they're eighteen…so therefore it was basically up to the GP just to do what he could.

Financial burden. The majority of parents interviewed raised the cost of services as a potential barrier to accessing professional help. Whilst all of the parents interviewed were able to afford the cost of services and many had private health insurance, they all reported that paying for the treatment required was expensive. They also recognised that many other parents would not be able to afford the costs associated with treatment, and saw themselves as being quite fortunate in this respect. Parents reported being grateful that they were in a financial position which enabled them to provide their child with the help they required, and were at a loss as to describe how those less fortunate would be able to access professional services. They stated:

> I know it costs extra money to go and do it but you know, like with =Paul= it cost us thousands of dollars but it was worth it. But then again, that's not available to a lot of people so I really, I'm very thankful in life that at that time in our lives we could afford that…

> Well I mean that's just the typical thing, if you've got the money you can get better help, you really can. If you've got you know private health insurance and money to do things sadly you will go further I'm sure than the people who haven't.

> …and those that can't afford to do it well I don't know where they go. I really don't know where they go. I don't know how they get their medication, I don't know how they pay to see people, I don't know who they get that cares enough to take them to see someone. Just mind boggling all of that.

Mothers carrying burden of help-seeking. For interviewees, the process of actively seeking help was a role primarily left up to mothers. Whilst mothers reported that their husbands were concerned and supportive of their child receiving professional help, they tended not to take an active role in their child's mental health

care. Typically, mothers were responsible for organising and taking their child to appointments, liaising with professionals, monitoring their child's medication regime etc., and this placed significant pressure on mothers. For some women, their husband's lack of involvement created a sense of resentment and caused some tension within the marital relationship. Despite the burden felt by mothers, however, they tended to accept that being primarily responsible for negotiating pathways to care was implicit in their role as a mother. For example:

> I mean he was concerned all the time for her, very concerned, but he wasn't actually having to make appointments and get the medication and you know, sort it all out.

> I said, do you know what medication she's on? No. I said, do you know how often she takes her tablets? No. I said, do you know when she goes to the psychologist, do you know the psychologist's name?

> …All along when its come to anything about school or health that's kind of my job. I make the decisions there. I go to the meetings, I sort it all out, and that's just how it's always been. He's preferred it that way.

Attitudes towards mental illness and stigma. Parents felt a perceived stigma attached to their child being diagnosed with depression. Some parents found it difficult to discuss their child's depression with others for fear that their child would be perceived as being "mad" or "crazy". Parents also felt that the general public had a poor understanding of the true nature of depression. They felt that people were not as sympathetic to depression as they would be a physical or medical condition and that having depression signified some form of personal weakness in the eyes of others. The prevailing public attitude, as perceived by parents, was that depression is something that an individual has some form of control over that they should simply

"snap out of" or "get over". Thus parents felt that people did not understand depression and that having depression was associated with a degree of stigma. Examples of comments made by parents included:

> …people think oh yeah well you can just snap out of that, come on get going and you'll be right. I use to think that too, but it doesn't work like that. I think its really difficult um for other people to understand and there's such a stigma attached to it that a lot of people don't, you know, wanna tell anybody either.

> …I think there is still that sort of residue there um that perhaps there is you know, that if you were made of stronger stuff you'd be able to manage it.

Table 13

Matrix Display of Master Theme 1: Barriers and Burdens in the Help-Seeking Process

	Participant 1	Participant 2	Participant 3	Participant 4	Participant 5	Participant 6	Participant 7
Difficulty differentiating between developmental stage and depression	+	+	+	-	+	+	-
Symptoms of depression attributed to physical illness	+	+	+	+	-	-	+
Accessibility and availability of services	-	-	-	-	+	+	+
Financial burden	+	+	-	+	+	+	+
Mothers carrying burden of help-seeking	+	+	+	+	-	+	+
Attitudes towards mental illness and stigma	+	+	-	+	+	+	+

Master Theme 2: Facilitating Factors in the Help-Seeking Process

In contrast to those negative experiences which hampered the help-seeking process, parents also reported positive experiences that aided in the help-seeking process. Parents identified positive characteristics of themselves and their support networks that worked to facilitate the help-seeking journey and create better outcomes for their child. The types of factors which facilitated this process were separated into sub-themes to reflect the characteristics of parents, the characteristics of professionals, and the role of informal support in creating positive help-seeking experiences.

Theme 1: Parental Characteristics

Common characteristics of interviewees were identified that influenced the success of their help-seeking experience. Being determined and having confidence in their abilities as parents, and also having had prior exposure to depression, were factors that assisted parents throughout the help-seeking process.

Parental determination and perceived self-efficacy. A common characteristic of all parents interviewed was their strong determination and level of self-efficacy. Parents displayed confidence and belief in themselves and in their role as parents. They were prepared to question the advice of professionals and were able to assert themselves to ensure their child's needs were met. All parents demonstrated a "never give up" attitude and were prepared to persevere and persist until their child received appropriate help. For example:

> I did feel fairly competent as a parent and I feel fairly competent as an individual. I was prepared that you know, even if he said, "oh my god, you're here again" I probably would've still gone knowing that in the long run it was something that we needed to do.

> It was hard, it was really hard. I actually felt I had to have a lot of confidence in myself as a mother and I'm not sure that everybody would. I had to really pull out that…every ounce of strength I had to get her there.

> …we had to persevere, answers weren't thrown up for us along the way, we had to seek them out.

Prior knowledge or exposure to depression. Three parents interviewed identified some prior knowledge or experience with depression as having facilitated the help-seeking process. These parents reported that their past experience assisted them in recognising the symptoms of depression and in determining how and where to access help. These women also felt they had a unique understanding of what their child was going through that may not be afforded to other parents. Parents stated:

> …I guess because I do have an interest in depression and because you know I'm sort of lucky enough to be aware of some of the symptoms I was able to be able to approach it with him.

> Had I not perhaps seen so much of it in my husband's side of the family I probably would have been slower on the uptake... I'm seeing the signs perhaps earlier.

Theme 2: Characteristics of Professionals

Just as the characteristics of parents influenced help-seeking, characteristics of the professionals providing treatment also determined the quality of the help-seeking experience. For parents, feeling that their concerns were validated and that they were supported by professionals was important for their help-seeking experience to be perceived as a positive one.

Parents feeling that their concerns were validated. In determining the quality of help received from a particular professional, parents felt that it was important that they were listened to and that their concerns were taken seriously. Feeling that they were not being judged and having their concerns validated were critical in order for the professional encounter to be a positive experience. When their knowledge about their child was undervalued or their concerns minimised, parents felt quite disheartened and perceived these help-seeking experiences negatively. To illustrate:

> At the time I felt like if only we'd [*sic*] people had listened because perhaps that's one of the biggest things, is that I think as parents we actually knew a whole lot and we felt or I felt especially as a mum that people didn't listen and if people had been prepared to listen maybe the solutions would've been a bit more…

> …he always took it very seriously and it would be very easy to be flippant about it and to be perhaps a bit judgemental, but I never got the sense that he was um questioning my kids or um undervaluing our need to see him.

> Took me seriously, yeah. You know as a mother, I knew as a mother that that he wasn't well. I was the one who was up you know two or three times during the night when he'd come in and say "mum, I can't sleep". You know, I was the one in his room talking…I knew he wasn't right.

Professionals involving and supporting parents. For a help-seeking experience to be viewed positively, it was also important that parents felt supported and involved in the process. Many parents felt unsure as to how to manage their child's depression and being provided with advice and support from professionals was seen as being beneficial. Parents also expressed a desire to be informed about their child's progress and included in the treatment process. For example:

> He'd say something like "you're doing a really good job" to me. You know so that it was, you didn't feel like this overprotective, overanxious mother who was sort of fluttering around them and you know sticking your beak in where she really needn't have stuck it in. So I think, not only reassurance to the person who is experiencing depression, but reassurance to the parent too that actually you know, they are doing a good job.

> But it would've been most helpful if there was some discussion that we were involved in and I guess that said we were, by one of the psychiatrists, we were actively shut out. And by all of them we weren't drawn in and uh encouraged to understand the condition and that made it so much more difficult.

> They were quite adamant that we needed help, that it wasn't just =Jack=, they were quite strong that you need to get help…that was yeah like, "yes!". Someone's saying yes we need, recognising we need help to, we need help to deal with this.

Theme 3: Informal Support

All parents spoke about the importance of informal support in helping them to cope throughout the process. Having someone to talk to about what they were going through and how they were feeling was comforting for parents. Not only was it important for parents to have someone to talk to, but having someone who they felt genuinely understood what they were going through was a key aspect to this relationship being regarded as positive and supportive one. Parents also commented on their disappointment that support groups for parents of adolescents with depression were not available, feeling that sharing their experiences with other parents who were facing the same difficulties would have been beneficial. Examples of this were:

> …I just needed somebody to talk to who understood where I was coming from too and it was great. So yeah, we sat on the phone because he's in Melbourne and we talked and talked and talked and talked and you know he, he, he helped too because he knew it was very real too.

> …they actually understood what was going on. And you can talk to other people who make all the right noises but you know that they don't understand, really got to have been there to, to, to really know.

Table 14

Matrix Display of Master Theme 2: Facilitating Factors in the Help-Seeking Process

	Participant 1	Participant 2	Participant 3	Participant 4	Participant 5	Participant 6	Participant 7
Parental determination and perceived self-efficacy	+	+	+	+	+	+	+
Prior knowledge or exposure to depression	+	-	-	+	-	+	-
Parents feeling that their concerns were validated	+	+	-	+	+	+	+
Professionals involving and supporting parents	+	+	-	+	+	-	+
Informal support	+	+	+	+	+	+	+

Discussion

Summary of Findings

Study 2 examined qualitative accounts of the help-seeking experiences of parents of adolescents with depression living in a regional area. By exploring the experiences of parents who have sought help for an adolescent with depression, this study aimed to provide a more comprehensive understanding of how this parent-mediated process unfolds in the context of a regional setting. Results of this study

revealed common themes relating to barriers that parents of rural adolescents face in the help-seeking process and also factors that facilitate this process.

In terms of barriers, parents reported difficulties in differentiating between the developmental characteristics of adolescence and the symptoms of depression, and a tendency to attribute symptoms of depression to a physical illness, both of which created delays in problem recognition and subsequent treatment. As they negotiated their way through care, parents also reported challenges in the accessibility and availability of services. Parents reported a lack of services specialising in adolescent mental health in their town, and perceived travel required to access services demanding. The financial costs involved in accessing treatment were also highlighted as a barrier in obtaining appropriate care.

Mothers in this study fulfilled the primary role of help-seeker. Whilst they considered this task implicit in their role as a mother, the responsibility of having to play this active role (e.g., take child to appointments, liase with professionals) created additional pressure for mothers and in some cases created tension within marital relationships. Finally, parents perceived a stigma attached to their child having depression, such that depression was seen as a sign of weakness by others in the community, rather than a legitimate illness.

As well as identifying barriers to help-seeking, parents also reported common factors which facilitated this process. Characteristics of parents were identified that aided in the process of seeking and obtaining care. These included parents being confident in their own abilities and having determination to persist to ensure their child's needs were met. Parents also reported that having prior knowledge or experience with depression assisted in the process, from the recognition of symptoms to knowing how and where to access help.

Parents also identified characteristics of professionals that influenced the quality of their help-seeking experience. For parents, feeling that their concerns were taken seriously and feeling that professionals involved and supported them throughout their child's treatment was very important. Finally, parents valued the role of informal support to assist them in coping in this process. Being able to share their experience with someone who understood what they were going through was important for parents.

Interpretation of Findings

To provide a more comprehensive understanding as to how the parent-mediated process of help-seeking unfolds in the rural context, Study 2 examined the unique experiences of parents of adolescents living in a regional area who had actually been through the process of seeking help for an adolescent with depression. Overall, the pathways that parents took in seeking care for their adolescent were unique and varied. In some cases appropriate help was found immediately whilst others had to "shop around" before finding the help they required. The type of professional help that proved to be beneficial also varied (e.g., GP, psychologist, psychiatrist, school counsellor), evidencing little consistency between how and where parents sought help for their child. Whilst the pathways parents took to care were characterised as being varied, idiosyncratic, and at times convoluted, common factors were identified that either hindered or facilitated this process within a regional context.

In terms of barriers to problem recognition, parents reported difficulties differentiating between the developmental characteristics of adolescence and the symptoms of depression. Parents also reported an initial tendency to attribute symptoms of depression to a physical, rather than a psychological illness. In both

cases, parents' misattribution of the symptoms of depression to another cause created delays in problem recognition and, in some cases, time and resources were wasted in seeking help from less appropriate sources (e.g., naturopath). Perhaps, as in the case of Study 1, parents must perceive the problem to be over a certain threshold of severity before they recognise that the problem is one that requires professional help. That is, parents must come to decide that the behaviours they are observing are more severe than "typical adolescent behaviour" or minor physical ailments (e.g., stomach ache) and seek help accordingly. Once parents have sought help, the responsibility of identifying the problem type lays in the hands of the treating professional, presenting important clinical implications for those professionals whom parents first turn to for help.

When it came to actually seeking help, parents faced additional barriers including financial costs, issues with availability and access to services, stigma, and burden on mothers as help-seekers. Whilst parents in this study were typically of middle-class backgrounds and were able to manage the costs associated with seeking help for their child, they noted that treatment costs were expensive and would not be affordable to all parents. Recent changes to the public health (Medicare) scheme in Australia now enable those who access help from a psychologist for a mental disorder (including depression) to receive a rebate on the cost of their visit. For some of the parents interviewed, this rebate was not available at the time of seeking help for their adolescent and it is likely that this rebate would now reduce some of the financial burden experienced by parents in accessing treatment for their child.

Parents also reported frustration at the lack of services, particularly those specialising in adolescent mental health, available in their town. On occasions, parents reported being forced to travel out of town in order to access appropriate help, which they found burdensome. For parents who are unable to meet such travel commitments,

this may result in adolescents failing to receive the specialised treatment they need. Whilst parents did not make specific reference to these difficulties being related to rurality, issues of accessibility and availability have been commonly identified elsewhere (Aisbett et al., 2007; Jameson & Blank, 2007; Judd, Fraser et al., 2002; Judd & Humphreys, 2001) as barriers unique to rural setting. It is therefore likely that the difficulties parents faced in accessing appropriate services were due, at least in part, to living outside of a major metropolitan centre.

Parents also reported a perceived stigma attached to their child having depression. They felt that community attitudes towards depression were such that it was seen as a sign of weakness, rather than a legitimate illness, and that the general public lacked an understanding of the true nature of depression. Whilst this perceived stigma did not prevent parents in this study from seeking help on their child's behalf, it is possible that in some instances this degree of stigma would perturb parents from admitting that their child has depression, or from seeking psychological help for such a problem. Again, whilst stigma was not discussed in the context of rurality by parents, past research shows a strong association between stigma towards mental illness and living in a rural community (Boyd et al., 2007; Francis et al., 2006; Fuller et al., 2000; Parr et al., 2004) which may have impacted on the experiences of these parents.

A unique finding in this study was the level of burden experienced by mothers in carrying the primary responsibility of seeking help for their child. All mothers interviewed were married, but reported that their husbands tended not to play an active role in the help-seeking process, and that the role of help-seeker was one primarily fulfilled by themselves. Mothers did, however, demonstrate some ambivalence on this topic. On the one hand, mothers reported that they considered this task to be implicit in their role as a mother and caregiver, but on the other hand

spoke of some resentment and marital tensions experienced due to their husband's lack of involvement. Given that the current sample consisted predominately of mothers, it would be interesting to explore father's perspectives of this process. It could be possible that fathers experience the process as one in which they do not feel included or are inadvertently "shut out" by their wives. Future research would be needed to clarify this.

Also, whilst parental burden has been considered elsewhere (Angold et al., 1998), this has typically been in the context of burden predicting service use. That is, typically parental burden has been studied as a factor that initiates the help-seeking process. The present study therefore provides an alternative view on how burden is experienced throughout the help-seeking process, and what impact the act of seeking help has on mothers particularly.

In contrast to the barriers associated with help-seeking, common factors were also identified that facilitated the help-seeking process for parents. These included characteristics of parents, characteristics of professionals, and the role of informal support. For parents, being confident in their own abilities and being determined to ensure their child received appropriate help was identified as key to the success of their help-seeking experience. One possible interpretation of this finding is that a strong sense of self-efficacy in regards to their parenting role was an essential component of the help-seeking process for these parents. Self-efficacy reflects a belief in one's capacity to succeed at a task; the stronger one's perceived self-efficacy the more likely they are to persist at a task in the face of obstacles (Bandura, 1977). Whilst this finding is positive in that those parents who have a strong sense of self-efficacy will persist to ensure that their child receives help, parents who do not have the same level of self-efficacy may not be able to persist through the challenges of the help-seeking process.

Another parental characteristic that facilitated the help-seeking process for the parents interviewed was prior knowledge or exposure to depression. Parents reported having gained previous knowledge or experience with depression either through their professional background, having had a family member experience depression, or having experienced depression themselves. For parents, this past experience with depression aided them throughout the help-seeking process, from the recognition of the symptoms of depression in their child, through to knowing how and where to access help, and also in understanding and relating to their child's problem. This is also consistent with the finding in Study 1 that previous parental psychopathology predicted help-seeking intentions. Whilst prior knowledge and experience with depression was beneficial in facilitating the help-seeking process for the parents in this study, such opportunities or past experiences are not afforded to all parents. However, this does have implications for the role of educating parents about adolescent depression, in that improving parents' knowledge about depression may also improve their ability to identify and negotiate pathways to care for their child should they develop depression.

Characteristics of professionals also influenced whether the parents interviewed experienced the help-seeking process positively. Parents highlighted the importance of feeling that their concerns were taken seriously by professionals. They also felt that being supported and included in the treatment process by the professional was important to the quality of the help-seeking experience. These characteristics of professionals were critical to the help-seeking process being experienced as a positive one, irrespective of the type of professional (e.g., doctor, psychologist, psychiatrist) from whom parents sought help for their child. Whilst it is well established that the therapeutic relationship between clinician and patient is a determining factor in the quality of treatment outcomes (Zuroff & Blatt, 2006), this

finding has implications regarding the relationship between not only the professional and the client, but also the client's parent. When parents are playing a facilitating role in their child accessing professional help, it is important that professionals also take into consideration their relationship with the parent and ensure that parents' concerns for their child are taken seriously and that they too are supported.

Finally, informal support was viewed as a crucial coping strategy for parents throughout the help-seeking process. Parents reported that being able to share their experience with someone who understood what they were going through was comforting for them. This is supported by past research that has demonstrated that social support has a positive affect on parental coping (Puotiniemi, Kyngäs, & Nikkonen, 2002), acting as a buffer against stress (Scharer, 2005; Thoits, 1995) and being associated with lower levels of parental distress (Venters Horton & Wallander, 2001). Whilst informal support appears to be a protective factor for parents in coping with challenges of assisting a child with a mental health problem through treatment, this does, however, present concerns for those parents who do not have good social support networks in place when attempting to support their child and negotiate pathways to care. In the next section, methodological limitations of Study 2 will be discussed.

Methodological Limitations

Participant recruitment and sampling issues were the main methodological challenges that limited the findings of Study 2. In Interpretive Phenomenological Analysis (IPA) a purposive approach to sampling is recommended, such that samples are small, homogenous, and clearly defined (Smith & Osborn, 2003). Initially, attempts were made to recruit parents through an adolescent mental health service using clearly defined inclusion/exclusion criteria. However, when this recruitment

strategy failed, participants were recruited via advertisements placed in a local newspaper. As a consequence, the sample criteria were loosened and parents with more diverse and varied experiences were included in the study than what was originally intended.

Another issue with the sample is that all parents lived in the vicinity of a large regional town, which would fall within the ARIA classification of Inner Regional Australia. As such, the sample in Study 2 did not match the Study 1 sample well in terms of remoteness from services. It is likely that for people living in more rural areas, such as the participants in Study 1, the barriers and challenges to help-seeking may be even greater than those experienced by the parents in Study 2. It could be speculated, therefore, that the findings of Study 2 underestimate the challenges for parents living in more remote rural areas. Also, only one father was represented in the sample for Study 2. Given the amount of burden reported by mothers in their role as primary help-seeker, it would be interesting to explore the experiences of fathers in the help-seeking process in greater depth.

Another methodological issue to consider in relation to the IPA approach is how the views and experiences of the researcher impact upon the research process. In this study, the student researcher's training in clinical psychology and alliance to the scientist-practitioner approach resulted in data focussed on factual and analytical aspects of the help-seeking process with less consideration given to the emotional aspects of parents' experiences. Whilst this analytical approach was consistent with the aims of this research, it suggests that the emotional aspects of parents' experiences may warrant further attention in future research.

Finally, the qualitative and exploratory nature of Study 2 means that these findings relate only to the characteristics of this sample. Whilst such an approach was considered appropriate given the early stages of this research area, future research

using a larger, more representative sample and quantitative methods is needed in order to substantiate these findings and generalise them to a broader population.

In summary, the limited research to date examining parent-mediated pathways to help-seeking has focussed predominately on problem recognition and very little is known about how this process unfolds beyond this initial stage. Extending upon past research, results of Study 2 provide a unique account of the experiences of parents who have been through the process of seeking help for an adolescent with depression. The findings of the present study provide uncharted insight into the challenges that parents face when seeking help for an adolescent with depression in a rural/regional context, including those affecting initial problem recognition (i.e., difficulty differentiating between adolescence and depression, attributing symptoms to physical illness) through to those which influence the process of actively seeking help (i.e., accessibility/availability of services, financial costs, burden felt by mothers as primary help-seekers, and social stigma of mental illness). Additionally, these findings provide a valuable contribution to the area by highlighting factors that facilitated the process of help-seeking for parents (i.e., parental self-efficacy and prior knowledge/exposure, professionals involving/supporting parents and validating their concerns, and informal support). By considering the process of parental help-seeking in its entirety, the present study contributes much needed information about the role of parent-mediated pathways to care for rural adolescents with depression – including the factors which influence this process – and presents important implications for theory and practice regarding parental help-seeking, which will be discussed further in Chapter 4.

Chapter 4: General Discussion

Summary of Major Findings

The present research aimed to examine the role that parents play in mediating pathways to mental health care for rural adolescents with depression. Key findings from Study 1 indicated that parents of rural adolescents were able to recognise the severity of adolescents' problems and that their intentions to seek help increased with the severity of the problem. Parents tended to favour informal help sources, followed by doctors, school counsellors, and teachers, whilst parents who had a past history of a mental health problem themselves were more likely to recommend mental health professionals.

In Study 2, factors which function to inhibit or facilitate the help-seeking process for parents of rural adolescent with depression were identified. Barriers included difficulty differentiating between depression and adolescent development or physical illness, accessibility/availability of services, financial costs, burden felt by mothers as primary help-seekers, and perceived stigma of mental illness. Facilitating factors included parental self-efficacy and prior knowledge/exposure, professionals involving/supporting parents, and informal support. Overall, the present findings suggest that parents are in the position to play a valuable role in the help-seeking process for rural adolescents with depression. To consider this further, this chapter will discuss the theoretical and clinical implications of the present findings with view to directions for future research.

Theoretical Implications

Findings from the present research have important implications for theoretical models of parent-mediated help-seeking, and for the role of parents in facilitating

adolescent's pathways to care within a rural context. Regarding parent-mediated models of help-seeking, Logan and King (2001) proposed a 6 stage process whereby parents must first (a) come to be aware of their adolescent's distress, (b) recognise that the problem is psychological in nature, (c) consider options available for helping their child, (d) develop an intention to seek mental health services, (e) make an active attempt to seek out mental health services, (f) which leads to their adolescent obtaining psychological help. Past research in the area of parental help-seeking has predominately focussed on the first part of this model (i.e., problem recognition), with the present study being among the first to consider this process in its entirety.

Considering findings of Study 1 in the context of Logan and King's (2001) model, the present study found that parents were better able to identify the severity of the problem rather than the specific problem type, and that their intention to seek help increased with problem severity. This finding challenges the second step of Logan and King's model that (b) parents must recognise that the problem is psychological in nature, before considering possible courses of action. The results of Study 1 suggest that it may not be necessary for parents to identify that their child is experiencing a psychological or mental health issue for them to seek help. Rather, it may be sufficient for parents to identify the problem as being over a certain threshold of severity for them to develop an intention to seek help. For the problem to be correctly identified and diagnosed, however, it would then be necessary that whomever the parent turns to for help (e.g. a GP) has the skills necessary to identify the problem as being psychological, and either make a diagnosis of depression or refer elsewhere for this to occur.

Similar could be said of the study findings in the context of the fourth step of Logan and King's (2001) model, (d) develop an intention to seek mental health services. Findings of Study 1 indicated that less than half of parents would seek help

from a mental health professional, favouring doctors, school counsellors, and teachers as formal help-seeking options. This finding suggests that it parents first turn to a doctor, school counsellor, or teacher for help and these professionals were able to identify the problem as psychological, they would then be in the position to refer the parent to an appropriate mental health service. Rather than parents *themselves* having to develop an intention to seek help from mental health services as Logan and King's model implies, they may instead be directed to mental health services by other professionals. This suggestion also fits with observations from Study 2 that the pathways parents took to obtaining care for their adolescent were varied and idiosyncratic, rather than a logical and sequential path as proposed in this model.

Logan and King (2001) do, however, acknowledge that at each step along this pathway various factors may act to inhibit or facilitate parents in the process of obtaining care for their adolescent. Whilst past research has given some consideration to factors that may impinge upon this process (e.g., parental burden, parental psychopathology), findings in this area remain quite limited. Addressing this issue, this research examined predictors of help-seeking intentions of parents who had no prior help-seeking experience, and also retrospective accounts of parents who had been through the process of seeking help for an adolescent with depression. This research identified various factors that may act as barriers (i.e., difficulty differentiating between adolescence and depression, attributing symptoms to physical illness, accessibility/availability of services, financial costs, burden felt by mothers as primary help-seekers, and stigma) and those which may enable (i.e., parental self-efficacy and prior knowledge/exposure, professionals involving/supporting parents and validating their concerns, and informal support) the help-seeking process for parents of adolescents with depression. Whilst still an emerging research area, these findings provide a preliminary understanding as to how the parental help-seeking

process unfolds – including the factors that influence this process – and have important implications for future theoretical development in this field.

Findings of the present study also have important implications in the area of rural adolescent mental health in Australia. Whilst still an emerging research field, it is becoming increasingly recognised that rural Australians, including rural adolescents, experience distinct health inequalities and face additional barriers and challenges to mental health care compared to their urban counterparts (Aisbett et al., 2007; Boyd et al., 2006, 2007; Francis et al., 2006). Findings of the present study add to this field by highlighting the important role that parents can play in assisting rural adolescents to access mental health care. This study demonstrated that parents of rural adolescents are able to identify adolescent problems and are willing to seek help for an adolescent experiencing a problem. It also highlighted parental factors that may facilitate this process. Given that the majority of adolescents with mental health problems do not seek help on their own accord, and that rural adolescents face even greater barriers in doing so, this finding has promising implications for the role that parents of rural adolescent can play in assisting adolescents with depression to obtain mental health care.

In summary, the present research has important theoretical implications regarding parent-mediated pathways to help-seeking for adolescents, particularly within the rural context. Whilst the current findings generally support Logan and King's (2001) model, they do suggest that some steps in this process may not be necessary and may need to be reconsidered and revised through further research. With regards to rural adolescent mental health, the finding that rural parents may be in the position to facilitate this process for adolescents is a valuable addition to this research area, and worthy of further attention.

Clinical Implications

The present research raises a number of clinical considerations that have implications for the role of parents in mediating pathways to care for rural adolescents, and for rural adolescent mental health service delivery. With regards to problem identification, results from both Study 1 and Study 2 indicated that parents have some difficulty identifying and differentiating the symptoms of depression. However, results of Study 1 also demonstrated that parents are capable of recognising the degree of severity of a problem, and that they are more willing to seek help for an adolescent as this severity increases. This finding implies that whether parents can recognise that an adolescent has depression or a mental health problem may not matter if the person from who parents seek help is able to recognise this. Given that parents in Study 1 identified doctor, school counsellor, and teacher as their preferred help-seeking options, for this pathway to be successful it would be necessary that these professionals be able, at the very least, to recognise the types of symptoms and make an appropriate referral to services if they considered this beyond their professional ability. This places a significant amount of responsibility on such professionals, who may not necessarily be skilled or experienced in the area of adolescent mental health. To ensure that such formal supports are able to advise parents appropriately, consideration may need to be given to providing specific training or education around adolescent mental health/depression for these professionals. This could occur in the form of professional development training sessions or might even be worth considering as part of the tertiary education for these professions.

Alternatively, another way to address this issue would be to provide parents with education to assist them in identifying symptoms of depression and in distinguishing between problematic behaviour and developmentally appropriate

("normal") adolescent behaviour. This suggestion is consistent with the finding in Study 2, that prior parental knowledge about depression facilitated the help-seeking process. For these parents, having prior knowledge about depression assisted in their identification of their adolescent's problem and suggests that providing parents with education to increase their knowledge may also have similar benefits. Such education could be provided through information forums being held at local high schools or community centres, or through educational campaigns in the media. Offering parents accurate information about developmental characteristics of adolescence and how to differentiate these from mental health problems would also assist in providing parents with the skills necessary to identify depression. Educating parents may also enhance parental self-efficacy, as improving their skills would make them feel more confident in their ability to manage this problem. Finally, providing such education would create increased community awareness around adolescent mental health, which in turn may assist in reducing the stigma associated with mental health issues and mental health services and increase the likelihood that parents would consider mental health professionals an acceptable help-seeking option.

A further clinical implication to come out of this research was the need for professionals working with adolescents to also consider the needs of parents, particularly when parents have facilitated their child's pathway to care. Parents in Study 2 reported that feeling that they were listened to and that their concerns were validated and taken seriously by professionals was important. They also reported wanting to be more involved in their child's treatment. For the help-seeking experience to be a positive one, it is therefore important that professionals not only work with the adolescents, but that they also involve and support parents. If parents become dissatisfied or perceive the professional negatively it is unlikely that they will

want their child to continue receiving this care and will look for other options, thereby extending the time between problem onset and treatment for the adolescent.

The importance placed on the role of informal support by parents was a significant finding to come out of Study 2. Whilst the value of informal social support has been discussed extensively elsewhere (e.g., Puotiniemi et al., 2002; Scharer, 2005; Thoits, 1995; Venters Horton & Wallander, 2001), the role informal support plays in parental coping has important implications for parents in managing the demands and burden associated with seeking help for a child with depression. Parents reported that having someone to talk to who understood what they were going through was critical to their coping throughout this process. Parents even commented on their disappointment that support groups for parents of adolescents with depression were not available as they felt sharing their experiences with other parents who were facing the same difficulties would have been beneficial. It is therefore important that professionals working with families who do not have their own close support networks are aware of this and consider options to provide parents with additional support. This might include community support groups, individual counselling, or pastoral care, for example. By ensuring parents have an avenue to share their experiences in an understanding and supportive environment, such support would provide a useful coping resource for parents facing the challenges and burdens of seeking help for an adolescent with depression.

Finally, the present study indicates that parents have the capacity and are in a unique position to assist rural adolescents with depression in seeking help. Parent-mediated pathways to care therefore present a viable option for overcoming some of the challenges faced by rural adolescents, improving their chances of accessing mental health care. However, issues of poor availability and access to mental health services in rural areas will continue to serve as a barrier to accessing specialised

mental health treatment for rural adolescents with depression, irrespective of parents' willingness to assist them in seeking help. The very fact that parents may have an intention to seek mental health care for their child but are unable to do so because of accessibility and availability issues such as a lack of services or transport constraints is a shortcoming of mental health service delivery in rural Australia. If not addressed, this will remain an ongoing challenge for those living in rural areas, and continue to place rural adolescents at a disadvantage in terms of their immediate and long-term outcomes.

Directions for Future Research

The present study provides useful information regarding the role that parents can play in assisting adolescents, particularly those living in rural areas, to mediate the help-seeking process. However, research into parent-mediated pathways to care for adolescents, and for rural adolescent mental health service delivery in general, remains in its infancy. Continued research is clearly needed to broaden this knowledge base, and to further clarify this help-seeking process and the ways it can be improved to assist rural adolescents to obtain the mental health care they require.

To improve on the present study, future research should address the methodological limitations identified herein. In terms of research methodology, future researchers should consider the use of an urban comparison group. By comparing the help-seeking intentions or past experiences of rural versus urban parents, this will enable a better understanding of how the two groups differ, particularly in terms of those barriers considered unique to rural context (e.g., availability/accessibility of services, stigma). Also, given that the samples in both Study 1 and 2 consisted predominately of mothers, it would be interesting for future researchers to consider the experiences and roles of fathers in the process. So far, research on parent-

mediated pathways have perhaps more accurately reflected ‘mother-mediated pathways’, and it would be useful to consider the place of fathers in help-seeking for adolescents. Finally, the qualitative and exploratory nature of Study 2 was appropriate for the present purposes given the early stages of this research area. The benefits of the paradigm are that an in-depth appreciation of the experiences of parents can be obtained. The study has demonstrated the benefits of this to the understanding of the process of help-seeking and so further qualitative, exploratory research is justified. However, to extend upon this, future researchers could also consider the use of quantitative methods to verify the findings.

In terms of the theoretical and clinical implications of the present study, future research should consider ways to further clarify the process by which parents assist rural adolescents with depression in seeking help. This may include testing and revising existing theoretical models, such as Logan and King’s (2001), with particular consideration given to the present finding that identification of problem severity, rather than problem type, may be sufficient to initiate the help-seeking process. Also, further consideration should be given to the factors that influence the help-seeking process for parents to gain a better understanding as to how this process unfolds. This might include looking at ways to minimise the barriers or strengthen facilitating factors identified in the current and past research to make the process of seeking help easier for parents. Such research may also assist in developing a more simplified and streamlined process by which parents can seek help for their adolescent.

It may also be worthwhile to consider the utility of some of the clinical suggestions made here in future research. For example, the present study suggested providing further education to parents and professionals around adolescent mental health. Future research could examine whether this approach would be effective, how such education could be delivered, and whether this approach would be better targeted

at parents, professionals, or the general community. Consideration could also be given to how such education programs might impact on factors identified in this study such as increasing parental knowledge, reducing stigma, or enhancing parental self-efficacy. Also, research examining the efficacy of support groups for parents of adolescents with depression, or how professionals providing support to parents influence treatment outcomes may be worthwhile.

Finally, research should continue to address the unmet mental health demands and service needs of rural adolescents in Australia. Whilst parent-mediated pathways offer some hope in assisting adolescents with depression in rural settings to overcome some of the barriers they face in seeking help, a lack of available and accessible services in rural areas continue to place these adolescents at a disadvantage. The National Mental Health Plan (Australian Health Ministers, 2003) states that "access to and quality of care should be equitable, and people should not be disadvantaged by, for example…living in a rural area" (p.10), however, research to date suggests that the reality for rural adolescents falls considerably short of this ideal. Research in this area, therefore, needs to be persistent and ongoing. By continuing to highlight the plight of adolescent mental health service delivery in rural Australia, it is hoped that the mental health needs of these adolescents will gain greater recognition in Government planning and policy, and that specific initiatives will be developed to address the mental health service needs of rural adolescents in Australia.

Summary and Conclusions

The present study demonstrated that parent-mediated pathways to help-seeking offer a promising way to assist in bridging the gap between those adolescents who have a mental health problem and those that access mental health services, particularly in rural areas. Key findings showed that parents of rural adolescents are

able to identify the severity of adolescent problems and are willing to seek help accordingly. Results also highlighted the significant barriers that parents face in seeking help for an adolescent with depression, as well as the factors that assist in facilitating this process. These findings extend beyond those of past researchers by exploring help-seeking beyond the initial stage of problem recognition to consider parent-mediated pathways to help-seeking in their entirety. This study is also unique in that it considered how these parent-mediated pathways apply to rural adolescents, who are gaining increasing recognition as a disadvantaged population in terms of access to mental health services.

The present study also raises important theoretical and clinical implications for the current field of parental help-seeking and rural adolescent mental health. The current findings suggest that existing models of parental help-seeking may need to be revised to take into account the finding that identification of problem severity may be sufficient to initiate help-seeking. The present study also identified factors that influence the help-seeking process of parents and raised clinical suggestions in terms of the role that both parents and professionals have in identification of adolescent mental health problems, considerations for professionals working with adolescents and their parents, and the role informal support plays in assisting parents to cope throughout the process of help-seeking.

Points to consider for further research may therefore include testing and revising of existing models in the context of the present findings, and continuing to examine how factors identified in the present and past research influence the help-seeking process for parents. Also, future researchers may wish to consider how the development of education programs on adolescent mental health or support groups for parents of adolescents with depression might be of assistance.

In conclusion, the findings of the present study are optimistic regarding the role that parents of rural adolescents with depression can play in facilitating adolescent pathways to mental health care. Whilst this field of research is still in its early stages, the current findings provide a unique contribution to the area of rural adolescent mental health, by highlighting the significant role that parents can play in assisting rural adolescents to overcome some of the challenges they face in obtaining appropriate mental health care. However, ongoing research into rural adolescent mental health and mental health service delivery to rural areas needs to occur to ensure the mental health needs of rural adolescents do not continue to be overlooked in the future.

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Appendix A

Accessibility/Remoteness Index of Australia (ARIA+)

ARIA+ was developed as an unambiguously geographical approach to defining remoteness, and is widely accepted to be Australia's most authoritative geographic measure of remoteness (GISCA, 2006). ARIA+ assesses remoteness based on road distances from goods and services, and does not take into account socio-economic, urban/rural, or population size factors in its calculation. In ARIA+, the remoteness index value is based on road distance from a locality to the closest service centre in each of the five classes of populations sizes listed below:

A. greater than 250 000 persons

B. 48 000 to 249 000 persons

C. 18 000 to 47 999 persons

D. 5000 to 17 999 persons

E. 1000 to 4999 persons

ARIA+ index values are derived ranging from 0 to 15, with higher scores reflecting areas of greater remoteness. ARIA+ index values are classified according to the following categories:

1. Major Cities of Australia – ARIA+ index values between 0 and .20.

2. Inner Regional Australia – ARIA+ index values greater than .20 and less than or equal to 2.4.

3. Outer Regional Australia – ARIA+ index values greater than 2.4 and less than or equal to 5.92.

4. Remote Australia – ARIA+ index values greater than 5.92 and less than or equal to 10.53.

5. Very Remote Australia – ARIA+ index values greater than 10.53.

Appendix B

Socio-Economic Indexes for Areas 2001 (SEIFA 2001)

SEIFA 2001 was developed as a measure of different socio-economic conditions by geographical location using data derived from the 2001 Census of Population and Housing (ABS, 2003). SEIFA 2001 comprises of four indexes, with each reflecting a different aspect of the level of socio-economic wellbeing in an area. The four indexes are:

1. Index of Relative Socio-Economic Disadvantage: derived from factors such as low income, low educational attainment, high unemployment, jobs in relatively unskilled occupations and other variables that reflect disadvantage (e.g., dwellings without motor vehicles, indigenous, separated/divorced). Higher scores on this index indicate an area that has fewer families of low income, lower educational attainment, unskilled workers etc., whilst lower scores indicate a great number of families with such attributes. Thus, higher scores reflect a lack of disadvantage rather than high advantage.

2. Index of Relative Socio-Economic Advantage/Disadvantage: a continuum of advantage (high values) to disadvantage (low values). It takes into account variables relating to income, education, occupation, wealth, and living conditions. Higher scores on this index indicate that an area has attributes such as a relatively high proportion of people with high incomes or skilled workforce, whilst having a low proportion of people with low incomes and fewer unskilled people in the workforce. In contrast, lower scores indicate that an area has a higher proportion of people with low incomes, unskilled occupations etc., and a low proportion of people with high incomes or in skilled occupations.

3. Index of Economic Resources: reflects the profile of economic resources of families within a geographical area. This index focuses on variables relating to the income, expenditure, and assets of families such as family income, rent paid, mortgage repayments, and dwelling size. Higher scores on this index reflect a higher proportion of families on a high income, a lower proportion of families on a low income, and a greater number of households living in large dwellings. In contrast, lower scores reflect a high proportion of households on low incomes and more families living in small dwellings.

4. Index of Education and Occupation: reflects the educational and occupational profiles of communities. This index takes into account variables relating to the educational and occupational characteristics of communities, such as the proportion of people with a higher qualification or those employed in a skilled occupation. Higher scores of this index indicate a high concentration of people with tertiary qualifications, and a higher proportion of people in skilled occupations, compared to lower scores which reflect lower educational attainment, and higher numbers of people in unskilled occupations or who are unemployed.

SEIFA 2001 index scores are standardised with a mean of 1000 and a standard deviation of 100 for the collection districts. For the purposes of this research, the Index of Relative Socio-Economic Advantage/Disadvantage was applied, as it is the only index that provides a continuous measure of both disadvantage and advantage.

Appendix C

Demographics Questionnaire

Please complete the following background information questions.

Your age: ……

Your occupation: ……..

Your relationship to child (please tick ✓):

☐ Mother ☐ Father ☐ Guardian

Please indicate the highest level of education you have achieved (please tick ✓):

☐ did not complete high school ☐ Secondary ☐ Tertiary

Please indicate your current marital status (please tick ✓):

☐ Married ☐ Divorced ☐ Single

☐ Defacto ☐ Widowed ☐ Other (please indicate) …….……..

Have you ever experienced, or been diagnosed with, any form of psychological or mental health problem (please tick ✓)?

☐ Yes ☐ No

If you answered yes to the above question, did you seek professional psychological help for this problem (please tick ✓)?

☐ Yes ☐ No

Has your child ever experienced, or been diagnosed with, any form of psychological or mental health problem (please tick ✓):

☐ Yes ☐ No

If you answered yes to the above question, did you assist your child to seek professional psychological help for this problem (please tick ✓)?

☐ Yes ☐ No

Appendix D

Parent Help-Seeking Questionnaire (PHSQ)

In this section you will be asked to read a number of scenarios about adolescents who are experiencing some type of personal or emotional problem. After each scenario there will be a list of questions that you will be asked to answer.

Please read the following scenario carefully, and answer the questions that follow.

Emma, a high school student, was very upset when her boyfriend of four months, Ryan, broke up with her last week. Since then she has appeared sad and has had trouble concentrating in the classes she shares with Ryan at school. At home, she seems to be moping around the house and doesn't feel like eating much. Emma missed one session of basketball training the day Ryan broke up with her, but has been every time since then and appears to be excited about an upcoming tournament on the weekend.

Question 1
In the space provided below, please describe what type of problem you think Emma is experiencing.

_____

_____

_____

Question 2
Please tick one box below that you think best represents how serious Emma's problem is.

☐ Mild ☐ Moderate ☐ Severe

Question 3
Do you think that Emma needs help from someone else to manage her problem?

YES / NO *(please circle)*

Question 4
If you answered YES to the above question, please indicate which of the following people you think Emma should go to for help by ticking the appropriate boxes.

☐ Parents	☐ Teacher
☐ Other adult relative	☐ Doctor
☐ Friend	☐ Psychiatrist
☐ Psychologist	☐ Religious Minister
☐ School Counsellor	☐ School Nurse

Question 5
If *your own daughter* was experiencing a problem similar to Emma's, would YOU ask someone for help on her behalf?

YES / NO *(please circle)*

Question 6
If you answered YES to the above question, please indicate which of the following people YOU would go to for help if *your own daughter* was experiencing a problem similar to Emma's by ticking the appropriate boxes.

☐ Spouse/Partner	☐ School Counsellor
☐ Doctor	☐ Psychiatrist
☐ Friend	☐ Other adult relative
☐ Psychologist	☐ Religious Minister
☐ Teacher	☐ School Nurse

Question 7
Please circle the number below that best represents *how likely* it is that YOU would seek help from the following people for *your own daughter* if she was experiencing a problem similar to Emma's.

Spouse/Partner

1	2	3	4	5
Not at all likely				Very Likely

Doctor

1	2	3	4	5
Not at all likely				Very Likely

Friend

1	2	3	4	5
Not at all likely				Very Likely

Psychologist

1	2	3	4	5
Not at all likely				Very Likely

Teacher

1	2	3	4	5
Not at all likely				Very Likely

School Counsellor

1	2	3	4	5
Not at all likely				Very Likely

Psychiatrist

1	2	3	4	5
Not at all likely				Very Likely

Other adult relative

1	2	3	4	5
Not at all likely				Very Likely

Religious Minister

1	2	3	4	5
Not at all likely				Very Likely

School Nurse

1	2	3	4	5
Not at all likely				Very Likely

Please read the following scenario carefully, and answer the questions that follow.

For a long time now Jess, a high school student, has been moody and irritable and her parents cannot remember the last time she seemed really happy. She has always been an average student, and her school report cards often contain remarks such as "Jess appears to have difficulty concentrating and needs to apply herself more". At home, Jess spends a lot of time alone in her room and doesn't go out much. She often seems to be tired and low in energy.

Question 1
In the space provided below, please describe what type of problem you think Jess is experiencing.

_____

_____

_____

Question 2
Please tick one box below that you think best represents how serious Jess' problem is.

☐ Mild ☐ Moderate ☐ Severe

Question 3
Do you think that Jess needs help from someone else to manage her problem?

YES / NO *(please circle)*

Question 4
If you answered YES to the above question, please indicate which of the following people you think Jess should go to for help by ticking the appropriate boxes.

☐ Parents	☐ Teacher
☐ Other adult relative	☐ Doctor
☐ Friend	☐ Psychiatrist
☐ Psychologist	☐ Religious Minister
☐ School Counsellor	☐ School Nurse

Question 5
If *your own daughter* was experiencing a problem similar to Jess', would YOU ask someone for help on her behalf?

YES / NO *(please circle)*

Question 6
If you answered YES to the above question, please indicate which of the following people YOU would go to for help if *your own daughter* was experiencing a problem similar to Jess' by ticking the appropriate boxes.

☐ Spouse/Partner	☐ School Counsellor
☐ Doctor	☐ Psychiatrist
☐ Friend	☐ Other adult relative
☐ Psychologist	☐ Religious Minister
☐ Teacher	☐ School Nurse

Question 7
Please circle the number below that best represents *how likely* it is that YOU would seek help from the following people for *your own daughter* if she was experiencing a problem similar to Jess'.

Spouse/Partner

1	2	3	4	5
Not at all likely				Very Likely

Doctor

1	2	3	4	5
Not at all likely				Very Likely

Friend

1	2	3	4	5
Not at all likely				Very Likely

Psychologist

1	2	3	4	5
Not at all likely				Very Likely

Teacher

1	2	3	4	5
Not at all likely				Very Likely

School Counsellor

1	2	3	4	5
Not at all likely				Very Likely

Psychiatrist

1	2	3	4	5
Not at all likely				Very Likely

Other adult relative

1	2	3	4	5
Not at all likely				Very Likely

Religious Minister

1	2	3	4	5
Not at all likely				Very Likely

School Nurse

1	2	3	4	5
Not at all likely				Very Likely

Please read the following scenario carefully, and answer the questions that follow.

For the last month Hayley, a high school student, has been moody and irritable. She often has angry outbursts and fights with her parents. At other times she appears to be gloomy and "down in the dumps". Hayley had previously been a very good student, but recently her school grades have dropped, and in her last report card Hayley's teacher wrote that she was "easily distracted and didn't appear to be concentrating in class". When at home, Hayley spends a lot of time alone in her room. At dinner time, she reports that she doesn't feel hungry and only eats half of her meal. Hayley's parents think she looks thinner than usual and that she always seems tired and low in energy. Hayley was once a very good swimmer, but appears to have lost interest in swimming and no longer attends training sessions.

Question 1
In the space provided below, please describe what type of problem you think Hayley is experiencing.

_____

_____

_____

Question 2
Please tick one box below that you think best represents how serious Hayley's problem is.

☐ Mild ☐ Moderate ☐ Severe

Question 3
Do you think that Hayley needs help from someone else to manage her problem?

YES / NO *(please circle)*

Question 4
If you answered YES to the above question, please indicate which of the following people you think Hayley should go to for help by ticking the appropriate boxes.

☐ Parents	☐ Teacher
☐ Other adult relative	☐ Doctor
☐ Friend	☐ Psychiatrist
☐ Psychologist	☐ Religious Minister
☐ School Counsellor	☐ School Nurse

Question 5
If *your own daughter* was experiencing a problem similar to Hayley's, would YOU ask someone for help on her behalf?

YES / NO *(please circle)*

Question 6
If you answered YES to the above question, please indicate which of the following people YOU would go to for help if *your own daughter* was experiencing a problem similar to Hayley's by ticking the appropriate boxes.

☐ Spouse/Partner	☐ School Counsellor
☐ Doctor	☐ Psychiatrist
☐ Friend	☐ Other adult relative
☐ Psychologist	☐ Religious Minister
☐ Teacher	☐ School Nurse

Question 7
Please circle the number below that best represents *how likely* it is that YOU would seek help from the following people for *your own daughter* if she was experiencing a problem similar to Hayley's.

Spouse/Partner

1	2	3	4	5
Not at all likely				Very Likely

Doctor

1	2	3	4	5
Not at all likely				Very Likely

Friend

1	2	3	4	5
Not at all likely				Very Likely

Psychologist

1	2	3	4	5
Not at all likely				Very Likely

Teacher

1	2	3	4	5
Not at all likely				Very Likely

School Counsellor

1	2	3	4	5
Not at all likely				Very Likely

Psychiatrist

1	2	3	4	5
Not at all likely				Very Likely

Other adult relative

1	2	3	4	5
Not at all likely				Very Likely

Religious Minister

1	2	3	4	5
Not at all likely				Very Likely

School Nurse

1	2	3	4	5
Not at all likely				Very Likely

Appendix E

University of Ballarat Human Research Ethics Committee Approval Letter (Study 1)

Human Research Ethics Committee (HREC)

Research & Graduate Studies Office

HUMAN RESEARCH ETHICS APPROVAL FORM

Principal Researcher/Supervisor: C Boyd

Associate/Student Researcher/s: R Jamieson

School: BSSH

Ethics approval has been granted for the following project:

Project Number: A05-152

Project Title: Parent-mediated pathways to help-seeking among rural adolescents with depression

For the period: 01/02/2006 **to** 12/12/2006

Please quote the Project No. in all correspondence regarding this application.

PLEASE NOTE: Within one month of the conclusion of the project, researchers are required to complete a Final Report Form and submit it to the HREC Executive Officer. Therefore, a final report on this project is due on the **12 January 2007.**

If the project continues for more than one year, researchers are required to complete an Annual Progress Report Form and submit it to the HREC Executive Officer within one month of the anniversary date of the ethics approval.

Ethics Officer
18 November 2005

Appendix F

University of Ballarat Human Research Ethics Committee Final Report (Study 1)

Final Project Report
Human Research Ethics Committee (HREC)

1) Project Details:

Project No:	A05-152
Project Name:	Parent-mediated pathways to help-seeking among rural adolescents with depression

2) Principal Researcher Details:

Full Name:	Dr Candice Boyd
School/Section:	BSSH
Phone:	X9624
Fax:	X9840
Email:	c.boyd@ballarat.edu.au

3) Project Status:

Please indicate the current status of the project:	
☒ Completed **Completion date: / /**	☐ Abandoned **Please give reason:**

4) Special Conditions:

If this project was approved subject to conditions, were these met?	
☐ Yes	☐ No *** NB: If 'no', please provide an explanation below:**

5) Changes to project:

Were any amendments made to the originally approved project?	
☐ No	☐ Yes *** NB: Please provide details: Change in recruitment method for Study 2 – newspaper advertisements**

Final Project Report

Human Research Ethics Committee (HREC)

6) Storage of Data:

Please indicate where the data collected during the course of this project is stored:
Principal researcher's office – filing cabinet

6) Research Participants:

Were there any events that had an adverse effect on the research participants?	
☒ No	☐ Yes *** NB: Please provide details:**

7) Summary of Results:

Please provide a summary of the results of the project:
Study 1 – when presented with a hypothetical scenario of a depressed adolescent, parents were able to identify the severity of the illness at a rate greater than chance. Study 2 – Parents experience significant barriers to pathways through care when assisting an adolescent with depression to access services in a regional area.

8) Feedback:

The HREC welcomes any feedback on: • **difficulties experienced with carrying out the research project; or** • **appropriate suggestions which might lead to improvements in ethical clearance and monitoring of research.**

9) Signature/s:

Principal Researcher:	Dr Candice Boyd Print name:	**Date:**	03/07/08
Other/Student Researchers:	..... Print name: RACHEL JAMIESON	**Date:**	26/11/08
	..... Print name:	**Date:**	–

Appendix G

Department of Education and Training (DE&T) Ethics Committee Approval Letter

Department of Education & Training

Office of Learning and Teaching

SOS003135

Dr Candice Boyd and Ms Rachel Jamieson
University of Ballarat
PO Box 663
BALLARAT 3353

Dear Dr Boyd and Ms Jamieson

Thank you for your application of 11 November 2005 in which you request permission to conduct a research study in government schools titled: *Parent-Mediated Pathways to Help-Seeking among Rural Adolescents with Depression.*

I am pleased to advise that on the basis of the information you have provided your research proposal is approved in principle subject to the conditions detailed below.

1. Should your institution's ethics committee require changes or you decide to make changes, these changes must be submitted to the Department of Education and Training for its consideration before you proceed.

2. You obtain approval for the research to be conducted in each school directly from the principal. Details of your research, copies of this letter of approval and the letter of approval from the relevant ethics committee are to be provided to the principal. The final decision as to whether or not your research can proceed in a school rests with the principal.

3. No student is to participate in this research study unless they are willing to do so and parental permission is received. Sufficient information must be provided to enable parents to make an informed decision and their consent must be obtained in writing.

4. As a matter of courtesy, you should advise the relevant Regional Director of the schools you intend to approach. An outline of your research and a copy of this letter should be provided to the Regional Director.

2 Treasury Place
East Melbourne, Victoria 3002
Telephone: +61 3 9637 2000
DX 210083

GPO Box 4367
Melbourne, Victoria 3001

Victoria
The Place To Be

5. Any extensions or variations to the research proposal, additional research involving use of the data collected, or publication of the data beyond that normally associated with academic studies will require a further research approval submission.

6. At the conclusion of your study, a copy or summary of the research findings should be forwarded to the Research and Development Branch, Department of Education and Training, Level 2, 33 St Andrews Place, GPO Box 4367 Melbourne 3001.

I wish you well with your research study. Should you have further enquiries on this matter, please contact Chris Warne, Project Officer, Research on (03) 9637 2272.

Yours sincerely

Dr John McSwiney
Assistant General Manager (Acting)
Research and Innovation Division

30 / 11 / 2005

enc

Appendix H

Letter to School Principals

Dear (principal's name entered here),

My name is Rachel Jamieson and I am studying towards the degree of Doctor of Psychology at the University of Ballarat, under the supervision of Dr Candice Boyd. I am inviting interested rural and regional schools to participate in a study (with ethical approval from the Department of Education and Training) examining the role of parents in assisting rural adolescents with depression to obtain professional help.

Adolescent depression represents a significant mental health concern that can lead to a range of negative consequences, including impaired educational outcomes. Early and effective treatment is critical to overcoming the poor outcomes and prognoses associated with adolescent depression; however, many adolescents do not receive professional help. Parents have been identified as being in the position to play a key facilitatory role in helping adolescents to access processional help. As such, the purpose of this study will be to examine the ability of parents to identify depression and to assess the intended course of action they would take for such a problem.

As a participating school, students would be asked to take a questionnaire package home to parents. This package consists of two questionnaires: a general demographic questionnaire, and a parent help-seeking questionnaire. This questionnaire contains three hypothetical scenarios and a series of questions regarding the nature of the problem described in the scenarios, and how parents would respond to such a problem. Parents would be asked to complete the questionnaires and return them to the researcher via a reply-paid envelope.

Participation in this study by parents is voluntary and would involve no disruption to class time for students as it does not require their direct participation. It is not anticipated that participation would cause parents or their children any distress or discomfort, given that the questionnaire content is hypothetical in nature. In the unlikely circumstance that this should occur, all parents will be provided with the Lifeline telephone number should they require further help.

It is hoped that this study will make a valuable contribution to the area of rural adolescent mental health. If you are willing for your school to be involved in this study, or would like to find out more please contact the principal researcher, Dr Candice Boyd, on (03) 5327 9624 or via email: c.boyd@ballarat.edu.au.

Yours Sincerely,

Rachel Jamieson
Doctoral Student

Dr Candice Boyd
Principal Researcher

Appendix I

Summary of Research for School Newsletters

Research Project: Parental Identification of Adolescent Problems

Parents are invited to take part in a study examining the important role that parents play in assisting adolescents when they are experiencing a psychological problem. This research is being conducted by University of Ballarat doctoral student, Rachel Jamieson, and principal researcher, Dr Candice Boyd.

The purpose of this study is to understand how parents respond to adolescent problems, in the hope to provide a greater understanding of the role that parents play in helping adolescents. Participation is voluntary, and involves completing a short questionnaire. If you have any further questions about this study, please contact the principal researcher, Dr Candice Boyd, of the School of Behavioural and Social Sciences and Humanities, on telephone number: (03) 5327 9624.

Appendix J

Guidelines for Questionnaire Distribution

Dear Principal,

Thank you for agreeing to participate in the research project "Parent-Mediated Pathways to Help-Seeking among Rural Adolescents". Please find enclosed 100 questionnaire packages for distribution to parents via students.

Please follow the guidelines below when distributing questionnaires.

1) Questionnaires are only intended for parents of students in **years 7-12**, as this research is examining adolescents.
2) Only send **one questionnaire package home per family**. It is recommended that one questionnaire package be sent home with the eldest child in the family. This may be easily achieved by sending questionnaire packages home with your school newsletter.
3) There are two versions of the questionnaire packages: male and female. Male questionnaires are coded with a blue dot sticker on the envelope, female questionnaires are coded with a red dot sticker. **Please give male students questionnaire packages with a blue dot, and female students questionnaire packages with a red dot**.
4) Please ask students to give questionnaire packages to one of their parents to complete.

I have also included a short written piece outlining this study that you may like to put in your school newsletter. This may be useful in advising parents about the research project. Please note, it is important for the purposes of this research that the term 'depression' is not included in communications to parents. This research is aiming to measure the ability of parents to identify depression, and including the term 'depression' would pre-empt this.

Thank you again for your kind and generous support. With your assistance, it is hoped that this research will make a valuable contribution to the area of rural adolescent mental health. If you have any further questions about this study, please do not hesitate to contact myself, Rachel Jamieson, via email: rjamieson@students.ballarat.edu.au. Alternatively, you can contact the principal researcher, Dr Candice Boyd, on telephone number: (03) 5327 9624.

Kind Regards,

Rachel Jamieson
Doctoral Student

Appendix K

Plain Language Statement (Study 1)

Parental Identification of Adolescent Problems

Dear Parent,

You are invited to take part in a study examining the important role that parents play in assisting adolescents when they are experiencing a psychological problem.

The purpose of this study is to understand whether parents are able to identify the types of problems that adolescents can experience, and also to examine how parents would respond to such problems. By investigating how parents respond to adolescent problems, this research hopes to provide a greater understanding of the role that parents play in helping adolescents.

Participation in this study involves completing two short questionnaires. The first questionnaire asks some general information about you and your adolescent child. The second questionnaire contains three short stories that you will be asked to read and answer some questions about. Your responses to these questionnaires will be anonymous and confidential, and should take no longer than 30 minutes to complete.

Participation in this study is voluntary, and you are free to withdraw at this point, prior to the time when results are averaged. If you have previous experience in seeking professional psychological help for your child, your participation in this study is not required, because this research is aiming to examine the intentions of parents who have not had such experience before. Should you decide to participate in this study, please complete the following questionnaires and return them via post in the reply-paid envelope provided.

It is not anticipated that participation in this study will cause you any distress or discomfort, but should you feel upset or worried please contact **Lifeline** for further help on telephone number: **13 1114**

If you have any further questions about this study, please contact the principal researcher, Dr Candice Boyd, of the School of Behavioural and Social Sciences and Humanities, on telephone number: (03) 5327 9624

Yours Sincerely,

Ms Rachel Jamieson
Doctoral Student

Dr Candice Boyd
Principal Researcher

Should you (i.e. the participant) have any concerns about the conduct of this research project, please contact the Executive Officer, Human Research Ethics Committee, Research & Graduates Studies Office, University of Ballarat, PO Box 663, Mt Helen VIC 3353. Telephone: (03) 5327 9765.

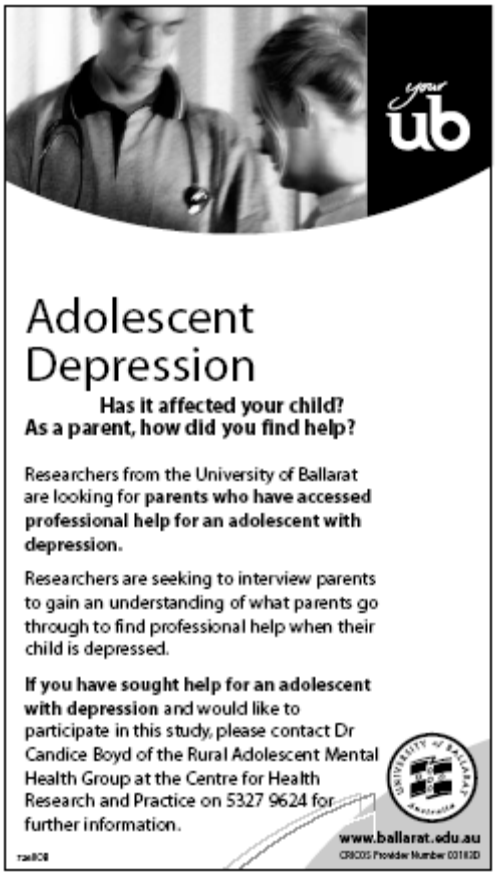
Appendix L

Clinician Ratings of Scenarios

	Scenario 1 (Mild) Nonclinical problem	Scenario 2 (Moderate) Dysthymic disorder	Scenario 3 (Severe) Major depressive disorder/episode
Clinician 1	4 mths = end r.ship, lowered mood, lowered concentration, loss of appetite. Above description suggests that Emma may be experiencing difficulty adjusting t the loss of the relationship with boyfriend. Significance of this depends on length of relationship and importance to her and also on what other social support she has. She appears to have mood difficulties which could be suggestive of mood disorder, however, if I had to diagnose based on this limited info I would be thinking adjustment disorder with depressed mood.	Time of onset unclear = irritable, perhaps lowered mood but not clear as only parents perception, academic difficulties ongoing, isolated, loss of energy. I don't think on this basis I would be able to diagnose anything because there is no detail of onset or symptom change, no clear idea of Jess' account of difficulties, no info on mood or affect. So I would think that there were some difficulties that need further exploration (and I might be thinking mood disorders)…	4 weeks = mood changes, increased irritability, reduced academic performance and concentration, socially isolating, loss of appetite, weight changes, loss of interest. Above would meet criteria for MDD – don't know if recurrent of single episode from this info.
Clinician 2	Emma is likely to be experiencing a normal loss reaction to the breakdown of her relationship with her boyfriend.	Jess may be presenting with signs/symptoms of Dysthymic Disorder (Early Onset).	Hayley may meet the DSM-IV criteria for a diagnosis of Major Depressive Disorder (Single Episode).
Clinician 3	No clinically significant issues.	Dysthymic disorder. On basis of available information, appears to meet criteria.	Major depressive episode. Meets DSM criteria A1, A2, A3, A6, A8. Meets DSM criteria C.
Clinician 4	No diagnosis; mild adjustment to stress, not in excess of expectation.	Dysthymic Disorder; early onset.	MDE
Clinician 5	Adjustment Disorder – Acute – with depressed mood.	Dysthymic Disorder	MDE
Clinician 6	Adjustment disorder – mild, acute.	Moderate depression	Mild-moderate depression

Appendix M

Newspaper Advertisement



Appendix N

Interview Questions

1. Please describe the circumstances that led to you assisting your child to seek help?

    a) What symptoms/behaviours was your child displaying?
    b) Did you identify their difficulties, or did your child approach you for help?
    c) If you did identify their difficulties, what made you recognise that they were experiencing a problem. Did you identify it as being a psychological problem?
    d) What made you decide that your child needed help?

2. When you realised your child was experiencing a problem, who did you turn to for help? What was their response?

3. How did you come to access (service name)?

4. What barriers did you encounter in trying to get help for your child? What made it difficult for you to access help?

5. How do you think the process could be improved/made easier for parents?

6. How would you describe your relationship with your child (e.g., are you close?)? How did your child respond to your assistance?

Appendix O

University of Ballarat Human Research Ethics Committee Approval Letter (Study 2)

Human Research Ethics Committee (HREC)

Research & Graduate Studies Office

HUMAN RESEARCH ETHICS APPROVAL FORM

Principal Researcher/Supervisor: C Boyd

Associate/Student Researcher/s: R Jamieson

School: Behavioural and Social Sciences and Humanities

Ethics Approval has been granted for the following project:

Project Number: A06-109

Project Title: Parent-mediated pathways to help-seeking among rural adolescents with depression

For the period: 4/8/2006 **to** 31/3/2007

PLEASE NOTE:

A final report for this project must be submitted to the HREC Executive Officer on:
30 April 2007

Ethics Officer
4 August 2006

Appendix P

University of Ballarat Human Research Ethics Committee Final Report (Study 2)

Final Project Report
Human Research Ethics Committee (HREC)

ALL QUESTIONS MUST BE ANSWERED.
Please type your responses into the boxes provided. Boxes will expand to fit your response.

1) Project Details:

Project No:	A06-109
Project Name:	Parent-mediated pathways to help-seeking among rural adolescents with depression

2) Principal Researcher Details:

Full Name:	Dr Candice Boyd
School/Section:	BSSH
Phone:	X9624
Fax:	X9840
Email:	c.boyd@ballarat.edu.au

3) Project Status:

Please indicate the current status of the project:	
☒ Completed **Completion date: 01 / 12 / 07**	☐ Abandoned **Please give reason:**

4) Special Conditions:

If this project was approved subject to conditions, were these met?	
☐ Yes	☐ No *** NB: If 'no', please provide an explanation below:**

5) Changes to project:

Were any amendments made to the originally approved project?	
☐ No	☒ Yes *** NB: Please provide details: change to participant recruitment method – newspaper advertisement**

Final Project Report
Human Research Ethics Committee (HREC)

6) Storage of Data:

Please indicate where the data collected during the course of this project is stored:
BSSH Archives

6) Research Participants:

Were there any events that had an adverse effect on the research participants?	
☒ No	☐ Yes * NB: Please provide details:

7) Summary of Results:

Please provide a summary of the results of the project:
Findings from Study 2 revealed key barriers as well as facilitating factors that influenced the help-seeking process for parents of rural adolescents with depression. Barriers included difficulty differentiating between depression and adolescent development or physical illness, accessibility/availability of services, financial costs, burden felt by mothers as primary help-seekers, and perceived stigma of mental illness. Facilitating factors included parental self-efficacy and prior knowledge/exposure to depression, professionals involving/supporting parents, and informal support.

8) Feedback:

The HREC welcomes any feedback on: • difficulties experienced with carrying out the research project; or • appropriate suggestions which might lead to improvements in ethical clearance and monitoring of research.

9) Signature/s:

Principal Researcher:	..... Print name: CANDICE BOYD	**Date:**	26/11/08
Other/Student Researchers:	..... Print name: RACHEL JAMIESON	**Date:**	26/11/08
	..... Print name:	**Date:**	

Please return to the Ethics Officer, Mt. Helen campus, as soon as possible.

Appendix Q

Plain Language Statement (Study 2)

Examination of the role that parents play in assisting adolescents to seek help

Dear Parent,

You are invited to take part in a study examining the role that parents play in assisting adolescents when they are experiencing a psychological problem. This study is being undertaken by Ms Rachel Jamieson and Dr Candice Boyd from the University of Ballarat.

The purpose of this study is to get a better understanding of the process that parents go through in assisting their adolescent to access professional help. By examining the experiences of those parents who have been successful in seeking help for their adolescent, this research hopes to provide a better understanding of the role that parents can play in helping adolescents.

If you decide to participate in this study, you will be asked to attend two interview sessions at the University of Ballarat, each lasting approximately one hour in duration. During these interviews, you would be asked to recount your experiences as a parent who has assisted an adolescent to seek professional help for a psychological problem. Interviews are conducted over two sessions in order to obtain a thorough and detailed account of people's experiences.

The interviews will be digitally recorded, but in order to preserve your anonymity and confidentiality, any identifying information would be removed when the tapes are transcribed into a written format. Any direct quotations used in the reporting of the results would be carefully selected so that an individual participant could not be identified. All data will be kept in secure and safe location for a minimum of 5 years after publication.

Participation in this study is voluntary, and you are free to withdraw at any time. The interviews are not intended to cause distress, but should you become upset we suggest you contact Lifeline telephone counselling services on 13 1114. If you have any further questions about this study, please contact the principal researcher, Dr Candice Boyd, of the School of Behavioural and Social Sciences and Humanities, on telephone number: (03) 5327 9624.

Yours Sincerely,

Ms Rachel Jamieson
Doctoral Student

Dr Candice Boyd
Principal Researcher

Should you (i.e. the participant) have any concerns about the conduct of this research project, please contact the Executive Officer, Human Research Ethics Committee, Research & Graduates Studies Office, University of Ballarat, PO Box 663, Mt Helen VIC 3353. Telephone: (03) 5327 9765.

Appendix R

Consent Form

UNIVERSITY OF BALLARAT
INFORMED CONSENT

Project Title: Examination of the role that parents play in assisting adolescents to seek help

Researchers: Dr Candice Boyd and Ms Rachel Jamieson

Consent (fill out below)

I, ... of . . . . . .

. . . . . .

hereby consent to participate as a subject in the above research study.

The research program in which I am being asked to participate has been explained fully to me, verbally and in writing, and any matters on which I have sought information have been answered to my satisfaction.

I understand that: all information I provide will be treated with the strictest confidence

and data will be stored separately from any listing that includes my name and address.

- aggregated results will be used for research purposes and may be reported in scientific and academic journals
- interviews will be digitally recorded
- I am free to withdraw my consent at any time during the study in which event my participation in the research study will immediately cease and any information obtained from it will not be used.
- once information has been aggregated it is unable to be identified, and from this point it is not possible to withdraw consent to participate

SIGNATURE: …… **DATE**: …….

Appendix S

Comments by Independent Auditor

I am an academic psychologist and member of the Clinical College of the Australian Psychological Society, who has published and supervised qualitative research in psychology. For this auditing task, I was supplied with audio recordings and transcripts of seven interviews, and a draft Results section of the thesis. I was not provided with the title or aims of the thesis, though from the explanation given to the first interviewee it clearly concerned parental experiences of assisting adolescents to find help for depression.

I listened to large excerpts of three of the recordings, in two cases reading the transcripts simultaneously. I listened to extracts from all the other interviews and read through most of the transcript material, ensuring I sampled early, middle and later parts of different interviews.

I can vouch for the fact that the transcripts accurately reflect what was said in the interviews. Very occasional missing or mistranscribed words made no appreciable difference to the sense of the transcripts.

The introductory statements before the interviews seemed a little impersonal, and perhaps a warmer atmosphere could have been created (perhaps some personal greetings had already happened). Nevertheless, there was no problem with the interviewees opening up. All were keen to tell their stories in order to help others, and were very talkative and articulate, with minimal input from the interviewer necessary – minimal encouragers, occasional paraphrasing and a few specific prompts were used judiciously. Interviewees were also given the opportunity to add anything further at the end of the interview. I am therefore confident that thorough coverage was achieved of the experiences of this sample of parents with seeking help for their depressed adolescents.

I noted that in the transcripts and Results care had been taken to anonymise all parents, adolescents, schools, mental health agencies and professionals. The only exception was that the regional town was identified by name in the draft Results. I am not sure whether this really matters, especially as in any publications the author's affiliation would probably make the location fairly obvious. Indeed, the location might be important to name if one of the follow-up activities of this study is to alert local organisations/governments to identified difficulties with service provision.

The themes identified in the draft Results captured well most of the issues that my superficial exposure to the interview material suggested. For example, the first two themes identified, of difficulty in distinguishing depression from normal teenage development, and initially focusing on possible physical explanations, I considered strong. The sample quotations used to illustrate the themes were appropriately chosen.

There was only one aspect of the draft Results that I felt could not be supported by the transcripts I read nor the illustrative material in the Results, and that was the classification of stigma as a barrier specific to the rural setting. While there may be other evidence that stigma about mental health issues is stronger in such environments (I doubt very much whether it is specific to them), this interpretation seems to go beyond the interview data. By contrast, other issues such as lack of local services and distances travelled to access some services were clearly identified as issues of rurality.

There was one particular issue that stood out to me from the transcripts that I did not see well represented in the draft Results, and that was the variety of pathways that help-seeking took. Some families were lucky, and found just the right person

immediately, in which case even a single session could be a turning point. Others, though, had to try several different professionals (e.g., see a different GP), while some help that was available was not used (e.g., the girl who would not see the school counsellor as she felt it would be stigmatising). For different families, different types of service provider proved to be the "right" one, whether a GP, psychologist, psychiatrist or school counsellor, and whether in an inpatient or outpatient facility. I was particularly struck by the family that was referred to a low-income service, but had this option removed in stressful ("horrific") circumstances when they turned out to be too well off financially – perhaps professionals need a reminder, with a view to improving services, that clarifying at the outset who is or is not eligible for various services is basic.

While the idea is certainly already captured in the themes that parents needed to be persistent, and that they needed to find a professional who would validate their concerns, I feel that the theme of varied, and sometimes convoluted, pathways to getting the right help, and that the "right' help is different for different families, could be brought out more clearly. Maybe it could be part of the "burdens to negotiating path to care" theme. Perhaps "pathways through care" might capture this better than "pathways to care" (just a suggestion – depends on when "care" is seen as actually starting – does the term refer to any professional contact or only to satisfactory and/or successful care?). I think that knowing that the path might be convoluted would be something that parents early in their journey might find helpful.

A few other smaller points I thought might be useful to include. One is that some parents thought that the public's knowledge about depression was much improved over the past few years, which they saw as helpful (I think this could be included in the theme about knowledge of depression already identified). Also, the role of siblings seemed to be important in various ways; in some instances this was with some relevance to the overall help-seeking theme, as when parents used older sibs as a point of comparison in trying to determine whether their child's behaviour was normal or not; other references to siblings were less relevant for help-seeking, perhaps, but as a theme of importance to parents maybe it should not simply be omitted.

Response to Comments by Independent Auditor

Classification of stigma as a barrier specific to the rural setting. Addressing the auditor's comments regarding classification of stigma as a barrier specific to the rural setting, the researcher reviewed the interview transcripts and agreed that the auditor's recommendation that this theme was not supported by the interview data was well-justified. Whilst parents identified stigma as a prominent factor in the help-seeking process, they did not make any specific reference or relate this in any specific way to rural location. This interpretation therefore went beyond the interview data, and was likely influenced by the researcher's prior reading of literature which indicates that stigma towards mental health problems is stronger in rural communities. To address this, the researcher removed the theme relating to rural location, and grouped the sub themes *attitudes towards mental illness and stigma* and *accessibility and availability of services* within *Theme 2: Burdens in negotiating pathways through care*. Also, references to rurality in the sub theme on stigma were removed.

Varied pathways to care. The auditor's comments regarding the varied pathways that help-seeking took provided a useful overview of the help-seeking

processes of parents interviewed. However, two issues arise from this. Firstly, whilst the observation that the help-seeking pathways of each family were unique and varied was accurate and informative, this cannot be regarded as a theme. In keeping with the methodological approach (IPA), it is parents' interpretations of their experiences which are being studied. The observation that the pathways varied was not a common theme in these parents' experiences and thus cannot be counted as a theme. Alternatively, the varied pathways described may have been a direct result of a methodological limitation wherein the researcher resorted to recruiting participants through a newspaper advertisement rather than recruiting through a specified mental health service as originally planned.

Whilst commenting on the varied pathways to care does not fit with the research methodology and therefore could not be interpreted as a "theme", the observation that pathways to care were so varied is relevant to the overall research topic and discussion of parent-mediated pathways to care. As such, a paragraph was added to the results section commenting broadly on the varied pathways parents took in seeking help for there child, before introducing the common themes (barriers and facilitating factors) parents experienced in this process.

Public knowledge about depression improved. Through review of the interview transcripts, the researcher found some evidence that parents perceived that the public's knowledge about depression was improved; however, this did not stand out as a strong theme that was well-represented throughout the interviews. Referring again to the research aims and methodology, those parents that did comment that they felt public knowledge had improved did not link this to their own personal experiences as a parent seeking help for their child. As such, this was not included in the study results.

The role of siblings. Through review of the interview transcripts, the researcher acknowledged that siblings were mentioned by various parents. For some, this was as a point of comparison against the sibling with depression, whilst others mentioned how siblings were affected by their brother/sister having depression, how they supported them, or that siblings were not able to understand their brother/sister's depression. In terms of pathways to care, the use of a sibling as a point of comparison may have some relevance; however, this was only mentioned by two of the parents interviewed. As such, one would again argue that this is not well represented enough throughout interviewees to constitute a theme.